Paul Ginsburg: Good morning and welcome to the 20th Annual Wall Street Comes to Washington Conference.

I'm Paul Ginsburg, Professor at the Price School at University of Southern California, and Director of Public Policy at the Schaeffer Center for Health Policy and Economics at USC.

Twenty years ago, shortly after founding the Center for Studying Health System Change (HSC), I perceived that federal policymakers knew very little about health care markets, and that they could make wiser decisions if they were better informed. And this led to the large site visit projects that most of you are familiar with from HSC, and it also led to this conference, which was designed to elicit from Wall Street equity and bond analysts their perspective on
health care markets that are relevant to policymaking. And both the site visits and this conference turned out to be long-term endeavors.

I'm delighted that the Jayne Koskinas Ted Giovanis Foundation for Health and Policy recognizes the value of this conference by sponsoring the event for the third year. Through research and projects like this conference, the JKTG Foundation hopes to foster discussion about cost reduction, expanding access to care, and improving quality.

So I've already said the purpose is to give the Washington health policy community insights into market developments that are relevant to policy through a different source of information than we usually see, namely, the equity and bonds analysts.

Equity analysts advise investors about how profitable different publicly traded companies will be. And bond analysts advise investors on the likelihood of debt repayments of both for profit and not-for-profit companies. And in health care, much of the work of the debt analyst is on not-for-profit companies. Along with a thorough understanding of health care markets and the companies they follow, analysts closely follow public policy which they see often having important implications for these companies.

And today is really an opportunity for the equity and bond analysts to take a break from assessing the outlook for profitability or solvency of companies and bring their understanding of market forces to bear on key health policy questions.

The format is a roundtable discussion. I have prepared a, always too long, series of questions that I've shared with the analysts in advance. Someday I ought to go and look at the questions that didn't get asked. See if they should have gotten asked.

There will be two opportunities for audience questions and answers, the first before we take a break at 10:30, and the second before we adjourn at noon. And there are blue question cards in your pocket. Please them out and give them to the conference staff member. Or if you want to make sure your question is answered, you can get up to one of the microphones and ask your question.

Note that the analysts are not permitted by their employers to answer questions about the outlook for specific companies. A transcript and a webcast of this conference will be posted on the Foundation website later this week. And before you leave today, we'd appreciate it if you could take a moment to fill out the evaluation. It's on a yellow piece of paper in your packet. And leave it on the table outside the meeting room.

We have a terrific panel this morning. Most are veterans of previous Wall Street Comes to Washington Conferences. That includes Matt Borsch of Goldman Sachs, Jim LeBuhn of Fitch Ratings, and Sheryl Skolnick of Mizuho Securities. And we're delighted to welcome a new panelist, Ana Gupte, of Leerink Partners.

Since this is the 20th Anniversary of the conference, I thought it would be fun to start off with a few comparisons between 1995 and 2015 in terms of health care spending. All of these figures
are from the National Health Expenditure accounts. The 1995 numbers are actual spending, and the 2015 numbers are projections.

So, total U.S. spending in 1995 was slightly more a trillion dollars, and spending has more than tripled to a projected $3.2 trillion and change. And during the same period, per capita spending grew from $3,826 to $10,125. All health care spending as a share of GDP grew from 13.4 percent to around 18 percent projected.

Looking at broad spending categories, hospital spending has grown from $340 billion annually in 1995 to just over a $1 trillion today. Similarly, spending on physician and other clinic services has just about tripled from $222 billion to $640 billion, and spending on prescription drugs has experienced a more than quintuple increase from $59 billion to a projected $328 billion this year.

So I'm going to go on. I think you have the bios of the people, of the four panelists that you can read at leisure, but I want to jump into the first question, a question that I think three different people from the audience asked me on the way in, and it's about insurance mergers.

So to what extent are the proposed mergers of major insurers, particularly Anthem with Cigna, and Aetna with Humana, a response to company-specific issues, or to broader changes in health care financing or delivery?

Who would like to take the first crack at that?

**Ana Gupte**: So I think it is definitely being catalyzed by the Affordable Care Act. There are a few company-specific factors, but it is, it's underpinned by some really broad trends, I think, post the Affordable Care Act.

The first one I'd say is regulation which has limited the profitability for these companies to a great degree, the caps on medical loss ratio (MLR) floors, the rate reviews which really limits the pricing and underwriting that they can undertake.

Secondly, I think there is also the consolidation that's occurring on the provider side of the equation, and that's an important trend that they have to respond to as a result of which I think you're seeing the consolidation that's now being undertaken in the health insurance sector as well.

And then thirdly, I say that a little bit more it's the broader health care overall situation. It is related to the ACA but not specifically related to the legislation that's associated with Obama Care. We've had privatization, broadly speaking, in the Medicare and the Medicaid space.

Aetna, I think, is largely doing this acquisition with Humana because they want to diversity away from a slowing growth commercial employer sponsored marketplace and shore up their Medicare capabilities.
On the Anthem/Cigna side, I think the fact that we have the Cadillac tax in 2018, I think is going to drive more of a shift from the group insurance market to individual. Cigna is not very strong in individual. Anthem does not have the self-insured and Star Plus capability in the smaller end of the group employer market, so together they can bring a more complementary set of capabilities to service the entire spectrum of employers from small group to middle market and all the way to national accounts.

So I think it is more, you know, just in a nutshell, it's more the broader trends and catalyzed than it's company specific.

Paul Ginsburg: Yes, Matt.

Matthew Borsch: I agree with those points. I just want to expand on a few others. I think there is a desire on the part of the companies to engage in the mergers to boost earnings growth, which they can do through recognizing cost and revenue synergy. So if you will, some real and some paper financial engineering at a time when regulation has made things tighter and in some areas earnings growth more challenging.

Relative to regulation, I think the increased burden of regulation has brought some regulatory economies of scale that may apply. Having said that, I'm not sure that that would meaningfully change at the scale that these companies are already operating.

And the last thing might be as, perhaps, a secondary rationale for the mergers, the ability to concentrate the members or the patient lives in population-based reimbursement or risk contracts.

And what I mean here is when I think back to working in the industry in the late '90s, working with provider groups that were looking to take on risk contracts, one of the challenges that we found is that we enter into a couple of payer contracts and that was about as far as could go and it would represent 10 percent of the medical group's lives, and that was pretty hard to change behavior or to get the law of large numbers with that. So that's another motivator.

Paul Ginsburg: Sheryl.

Sheryl Skolnick: So first I'm required by our general counsel to tell you that what I'm about to say is purely my opinion and not necessarily that of my employer, Mizuho Securities USA. Having said that, most of what I'm going to tell you is already published on their letterhead so you make the decision.

So one of the factors that I think needs to be weighed in here is there's this phenomenon of once the companies start talking about consolidation of such a large scale and the potential upside from all of this consolidation, they get their shareholders very engaged and very excited.

So I'll say once you go down that path, the final reason for these mergers is because their shareholders wanted it. Unfortunately, for the shareholders they got it because the stocks promptly went down.
But I would just as a highlight say that when you're dealing with for-profit publicly traded companies, don't underestimate the impact of the very fact that they are a publicly traded company with a responsibility, fiduciary responsibility to their shareholders to undertake transactions and strategies that may at the end of the day not be as optimal as they would have started out to be.

When you have companies negotiating with each other or fighting with each other over an asset in the press, it does tend to raise the price to significant levels above where they would have otherwise been. So that's part of the role.

The other thing is, I'm intrigued by Ana's comment about provider consolidation. One of the things we're not seeing is consolidation among the large for-profit hospital companies. You're seeing some one-off acquisitions, but, if anything, you're seeing separation with Community trying to split into two companies rather than consolidation.

You're seeing it onesie, twosies in the marketplaces because all health care is local. But I do think that there is an argument that the health plans would very much like to make, and as you might suspect, I cover more providers than I do plans, although I do cover both, that they need leverage in negotiating rates with hospitals because hospital rates are the big burr in the side of the health plans.

And in order to do that, you have to develop local market scale, not just national market scale because all health care, again, is local. And so one of the factors may be sort of behind the scenes, the monopsony power of these acquisitions that they might create local markets, and to create networks that will service the enhanced Medicare Advantage, the growing Medicaid managed care, and the still strong, although complex and changing commercial market.

That’s something that I think is a secondary thought, part of the thought process initially, but may ultimately be where the battleground is.

Paul Ginsburg: Jim.

James LeBuhn: And along those lines, unlike for the for-profits space, we're seeing a lot of mergers and acquisitions in the not-for-profit space, and I think the insurance consolidation is just going to be another thing that's driving that.

I think what we've seen is that the not-for-profits generally they've been very fragmented and so the M&A, the movement towards more strategic M&A has been for two reasons: To gain efficiency of scale, which they've never had, and then also the idea that we're moving towards risk-based population, health-based reimbursement. They've got to have the size and scale, which as Matt was saying, on the provider's side they weren't able to do that in the '90s because of the fractured nature of the hospital market. And so I think you're seeing the not-for-profits realizing that and strategically understanding that they need to come together for efficiency to enter into these population health reimbursement models.
And I would say lastly, although it's probably not said, is to gain leverage in terms of their insurance negotiations, their rate negotiations.

**Paul Ginsburg:** Yes, it's possible the Affordable Care Act is as much a catalyst as a driver given the things that have come up.

Let me ask the panelists, assuming these mergers are approved, perhaps with some divestitures required, will insurance purchasers pay more or less for health insurance as a result?

Ana Gupte: I can take that again, if you like. I believe I'll start, and then let's see what the others think. You know, I'm biased in favor of the mergers actually going through.

The medical loss ratio floors that I alluded to earlier have been an enormous burden, I think, on these companies. And as a consequence, the medical underwriting margin that they can earn in the return on capital does tend to get fairly limited.

We've seen that now in the commercial markets in 2011. We have this now in the Medicare Advantage market starting 2014. The Medicaid markets already have that at the state level. There is a federal regulation that's in play at the moment and needs to be finalized by CMS.

The scale, in my view, will give them the ability to some degree, as my co-panelists have talked about, to negotiate better with the provider side of the house, manage utilization better through value-based care and other approaches, but also fixed cost leverage, really, and fixed cost efficiencies.

It's mainly kind of a GNA story, I think, that they can enjoy or take to the bottom line. The rest of it because of the loss ratio floors, they need to use that to a large degree just to gain share, but the margin capabilities are fairly limited.

Secondly, I think they're moving more and more from a commercial employer sponsored marketplace to a Medicare and Medicaid marketplace. On the Medicaid side of the house, I mean, the state Medicaid agency has so much buyer power that frequently these companies are dealing with at least 12 months of losses in any new contract.

So I really don't sort of see how a merger is going to make that any different because they're not, they hardly have any negotiating power whatsoever.

And, again, on the Medicare side, the rates are set at the outset in February and April on a preliminary and final basis, and then they get to tweak their benefit design within a box of different parameters that they have to negotiate with CMS. So, again, I really don't see how this will drive down their medical loss ratios or increase their margins on the medical side. And it should help consumers.

**Paul Ginsburg:** Matt.
Matt Borsch: Just to add to that, I mean, I think the answer is we don't know. We may never know. On the one hand, I agree with Ana that there is definitely cost, economies of scale efficiencies that over time, presumably, will work their way into prices.

On the other hand, it's hard to see that concentration in markets won't have some effect on the prices that groups and individuals are paying as well. Which one will outweigh the other is hard to say.

In terms of the impact of regulation on pricing, whether it's from the MLR floors or from rate regulation, my observation there, regulation is rarely as efficient as competitive pricing as a mechanism for finding the right place for price. It's not yet clear what impact the MLR floors are going to have on insurance pricing over time.

It does seem that the MLR floors have led to more stability in margins across the industry. Whether that has generated net savings for consumers remains to be seen, but maybe that reduction of volatility in of itself is a good thing.

My last point on the concentration when we think of it from the purchaser's side, I would agree with Ana's point about Medicaid. It isn't clear, it's a little less clear in my mind on Medicare Advantage. You think about Medicare Advantage and the concentration that we have in that program, it's not entirely clear who has the leverage there. Is it the federal government or is it the carriers where three of them together have more than 50 percent share with the ability to change benefits year to year on a politically sensitive population.

Sheryl Skolnick: So, again, let me take a crack at this. I'm going to make an observation that may sound naive and cynical, but as a former antitrust economist, I can't imagine a merger of two powerhouses in a market not resulting in a higher price. It's just pure common sense. Okay. So that's where I come from. But, it's a higher, that's a question mark in a highly regulated industry, and this is. What I'll say is, I think, Matt, you nailed it. We're not sure. We may never actually know, and the reason is let's just go back to the basics of how a rational health plan sets price.

They set their price equal to their cost trend. Their cost trend is rising, therefore, price will rise. Whether it's coming from these mergers or not, prices are rising because cost trend is rising. You know, if you've been paying attention to the press, specialty pharmaceutical costs are rising really, really fast, and sometimes for some interesting reasons. So that may actually be resolved and that may take some pressure off cost trend in the next year or two, and we may actually see some abatement.

Building efficiencies in local markets will, getting better leverage, negotiating with high market share health care providers who are increasingly incentivized to become vertically integrated whether physically or virtually and build their own market share and market power, will that result in a lower cost trend that will allow reduced premiums or lower growth rates in premiums, which is more likely as a result of these mergers.
Theoretically, it could. Practically, you won't see it just because cost trend is rising. You'll never see it.

**James LeBuhn:** Well, I kind of agree. I think Matt hit the nail on the head in terms of the leverage against the federal government. As you see, this consolidation both in the provider space and in the insurer space because I think you're going to see the providers and the insurers, particularly on the MA side, their incentives are becoming more aligned. Obviously, they're going to have, there is going to be that friction, but in terms of medical costs rising and going back to the federal government and getting relief there, I think that that increases the leverage.

**Sheryl Skolnick:** But they've already gotten that. I mean, every time CMS has tried to price in a physician fee cut in the bad old days, the industry went to Congress and said, uh-uh.

**James LeBuhn:** Uh-huh.

**Sheryl Skolnick:** Not gonna take it. You know you're going to fix it so do something about it. I mean, that's just one example of the kind of leverage that you all are talking about which is interesting. Normally, we think of the industry, health care industry, as a recipient and price taker and the government negotiations, but in this case, it's a really interesting point.

**James LeBuhn:** Uh-huh.

**Paul Ginsburg:** And I think one thing that's different in Medicare Advantage is that since what the hospitals and physicians get paid is pretty much regulated and not really subject to market forces is that the provider payer leverage doesn't really come into play because at just as you say, the payer government leverage.

**Sheryl Skolnick:** Well, I actually disagree because you participate in a network under which you take Medicare, as a provider, you take Medicare Advantage patients. But that's as a result of a negotiation with the health plan. The range around it is much more limited than in a commercial negotiation because of the range, I would say, on the MA side.

**Paul Ginsburg:** Yes. I mean, I think it's very limited because if a hospital is out of the network, the hospital, and the patient goes there, the hospital can't get paid anymore. So that's what I mean by regulated. That they get paid Medicare rates and it's finally been researched. It's come out on that.

Ana Gupte: Just finally a point I just want to kind of a courter point to Jim and Matt's assertions around Medicare. Matt is a famous bear and I'm a bull so we obviously are on two ends of the spectrum here.

But for the last five years, the companies have seen an unbelievable amount of reimbursement reduction. And you can see this from the statutory filings. Companies like UnitedHealth have seen a tremendous amount of margin compression, as has Cigna, which bought supposedly the best of breed asset and now are operating at fairly, at less than half the margin that Health Spring had at one time.
And so I really would disagree with this point of view that the leverage is in favor of the industry relative to CMS here. I think that clearly the seniors come into play. I agree with that point. And it's politically sensitive and a very, relatively powerful political constituency.

But at the end of the day I think neither CMS nor the industry in this negotiation come out feeling like they won. You know, the Medicare was overpaid, Advantage at one point in time, and we've seen those payments come in to a large degree and now I think it feels to me sitting where we sit and you all have to tell us whether that's fair, that the push-back from the Democratic, you know, side of the House has been less because they're not over earning anymore. They clearly were at one point in time.

Matthew Borsch: Could I just -- and, actually, I don't disagree with what Ana said. You know, it's been a leverage dynamic between the federal government and the Medicare Advantage plans. If you go back to the time when the ACA was passed, and you recall the then head actuary at CMS, Richard Foster, had projected that Medicare Advantage enrollment would decline by 30 percent by 2016 as a result of the provisions in the Affordable Care Act.

And I think based on everything that he was looking at at that time, that actually wasn't such a crazy projection given the scheduled impact of the provisions in the ACA, combined with what at that time probably seemed like the most reasonable projections for underlying medical cost trend.

As we went along, what happened was I think the Obama Administration discovered that they really could not politically allow that type of impact on the MA program and so they introduced a number of measures that we all saw relative to MA reimbursement that effectively offset to a large degree the provisions that were scheduled to come through in the ACA such as the Star Bonus Demonstration Project from 2012 to 2014, and, of course, famously, the addition of the doc fix to the MA rates going into 2014.

And then finally, what you had I would just say in terms of keeping the MA program out of danger or out of maybe some of the danger it would have been in was how unprecedented the slowdown was, and underlying Medicare medical cost trend took some of the pressure off as well.

Paul Ginsburg: Okay, I better move on. Got some questions about provider and plan leverage. I think we've covered some of this. I want to go specifically into the fact that we've seen many examples in both the brand and generic drug space of manufacturers acquiring a drug and then raising the price sharply.

I want to ask is this a reflection of greater leverage for manufacturers perhaps due to the expansion of insurance coverage, including Medicare Part D, the ACA and applicability of out-of-pocket maximums, or is it something there was an opportunity that was always there and somebody just discovered it?
Sheryl Skolnick: I'll be happy to start with that one. So I don't cover the specialty pharmaceutical space, but I am the director of research for Mizuho, and one of my analysts… does. So I'm going to take some liberty with her views which are our firm's view as related by me in my personal opinion. Boy, my lawyer would be so happy.

So here's the take. First of all, you've got a bunch of good capitalists running these companies, and when they see an opportunity to use an alternative channel in order to distribute certain kinds of drugs, be they really mission critical drugs, or be they lifestyle or lifestyle enhancing drugs, for example, in the dermatology channel, they're going to go after that. And there clearly was an opportunity to go around some of the formulary restrictions and the structures set up by PBMs because we see evidence of it, and we see extensive evidence of it, and we see it having been extremely successful.

Is there an incentive for these guys as a result of regulation to do it? I don't think they needed any more incentive than the incentive that they had which was that there was a market-based opportunity that the market would bear these prices. And in particular, they did it by the good old fashion health care strategy of insulating the consumer from the true cost of the drug.

So you go in. You want your brand name for toenail fungus and guess what? You get it for free, or you get it with a $10 copay. Never mind that your health plan somehow is charged $1,000 for it with a gross margin that is probably close to 90 percent on it. So very, very profitable.

Now, having said that, they have to be very, very careful with Medicare because these manufacturers are not allowed to buy down copays with Medicare. And if you've been following all of the stories about Valeant and Philidor in the press, what you saw is they went to very great lengths on their conference calls to be very specific that they had controls around whether or not any of these copay buy downs were ever offered or given, more importantly, given, to any Medicare beneficiary.

How they did that without actually controlling Philidor is beyond me. They'll have to answer that one, I suspect, in court, but, and, certainly, in front of Congress. But for the record, Valeant is saying that they didn't give it to Medicare. So I don't think specifically that it was related to the Medicare Advantage. Medicare Part D is, essentially, Medicare Advantage together. Same issue.

On the ACA side, I think there was some acceleration, shall we say, of access to these kinds of drugs. My sense though is that there's not a whole lot of data on whether the newly insured ran out and got toenail fungus medication. I think they were more likely to run out to the emergency room to get more critical issues addressed that had been chronic because we know that there was an adverse election in the first go round, and et cetera, that there were real more, shall we say, acute or critical health care issues to address than some of these more lifestyle or longer term kind of chronic diseases that would be affected by some of the drugs that are most famously know for some of this pricing behavior.
But nevertheless, more coverage breeds more opportunity to buy down copays with jacked up prices on prescription drugs, and that's just reality. So I think it was a number of things, but the primary thing was there was a pricing umbrella. There was a mechanism insulating the consumer from the real, the true cost of health care and they were extraordinarily adept at finding a way to do that.

Paul Ginsburg: This is an example of innovation.

Sheryl Skolnick: Absolutely, if you could call it innovation. It's not always necessarily the kind of innovation we might like to see from a policy perspective, but from a stock market perspective, it was a great run.

Paul Ginsburg: That's right. Is Wall Street anticipating federal action to address this?

Sheryl Skolnick: Well, if they weren't, they sure are now. So let me just handle that for a second and then I'll cede the floor. When the first bomb was dropped with Shkreli, I guess his name, whatever, with the first one. Sorry, I can't pronounce his name. I tried. I don't want to butcher it. And with the first one coming out, when that first sailed over the traders' monitors and into their sight of vision which lasts about two split seconds, it was, okay, this is just a fluke.

And then when the second waive came and Bernie Sanders and Elijah Cummings said, hey, we want to bring these guys in front of Congress, there was another wave of, oh, oh. And then when the third thing happened which was Hilary's Tweet, and by golly, she's got a tiger by the tail with this one, every time she tweets now, these stocks have heart failure.

By that time, the question was -- no, it's true. By that time, the question was, you know, could this be real? Could they do anything? Does this have any legs? Now, after 27 years of dealing with scandals and health care because that's sort of the meat and potatoes of what I live for, and after 27 years of dealing with this, the answer is absolutely this has legs.

First of all, tremendous consumer, main street appeal. Those bad guys. They're gouging me. Second, election year politics. Come on. This is a brilliant, perfect topic to be talking about. There is no way a politician loses by going after these guys. Third, on top of that, we've now managed to box off Valeant and to a lesser extent Horizon, which seems not to have been doing the same things as Valeant but maybe using the same channel and some of the others that have been using the specialty pharmacy channel, which is a legitimate channel, by the way.

We've been able to box those off so there's not the issue that if a politician champions this notion on behalf of consumers and health plans and hospitals who have to pay these outrageous prices that they'll lose funding from Big Pharma someplace else because they've done a nice job of isolating it to a few bad actors. There was no way this didn't have legs.

And then the next wave was, well, it may have legs, but there'll never be congressional hearings. Yesterday, GOP finally agrees and the Oversight Committee will hold hearings. How could they not agree? It's political suicide not to agree in an election year to investigate what's
clearly a bad actor alleged behavior. It's a no brainer. This thing has legs. It's going through the election year. It's not going away. And by the time we're done, we may actually get some real savings out of it. If we don't, it would be a real pity and waste of resources.

**Paul Ginsburg:** Thanks. Let me move on to the marketplaces set up by the Affordable Care Act. I've seen some research that Matt published recently showing large losses for many of the non-profit Blue plans in their public marketplace business. So I want to ask what are the key factors driving the losses and what does it mean for the future?

**Matthew Borsch:** Well, Paul, I think, I mean, we can't on the basis of the quarterly filings determine all of the drivers product-by-product. But we can look at the loss ratios by product to some degree, at least. And, clearly, and this is also based on the public statements of many of the non public plans supplemented by recent commentary from the public companies, the ACA exchanges have been a huge driver of losses across the industry. Not every single plan. Even some not-for-profits like Wellmark famously have stayed out of the ACA exchanges. But most have been in and most have suffered considerable losses.

Whereas, the results in the core, non ACA commercial business have been much more steady and helped to, I mean, those companies would really be in a hard place if that business wasn't running if not really well, at least in a fairly stable level.

But I would go at that that there seems to have been some pressure on Medicare Advantage as well, again, for the not-for-profit companies, but most of it from the ACA exchanges.

**Ana Gupte:** I guess, again, it's hard to say from those SEC filings what really is exactly the driver, but to me, we can have opinions on what it likely is, and we do talk to the companies that we cover as to what they see the drivers likely to be.

So firstly, clearly, in 2014, we were expecting, and as it happened, the first comers are the ones with preexisting conditions so you have adverse selection on the exchanges.

The exchanges have very stringent rate review, and as a consequence, they're not entirely able to absorb all the losses that they're generating with all these sick comers that are overutilizing on procedures and services without kind of a balanced risk pool, if you will.

The Three Rs, as everybody has hoped and expected with the reinsurance, the risk corridors, and the risk adjusters were supposed to and are supposed to be (inaudible) backstop on the losses.

Reinsurance seems to have come through, clearly, for 2014, so far so good, and without that, the losses would have been even much worse than they are today. The risk corridor is, unfortunately, as we got into the end of September, CMS at this point has only paid out 12 percent of the total claimed risk corridors and that has sent a bunch of co-ops out of business, but has not left the publicly traded insurers unscathed.
In fact, Humana is now in the second year of tremendous losses on the exchange. They've been trying to subsidize some of those losses with the Medicare Advantage book and some speculate that maybe they would not have had to sell the company had they not been in such a bad position where they're seeing 15 percent of their earnings being lost within the exchanges and are not sure if they reach break even next year as well.

Finally, and I think this is really a troubling trend. In the third quarter of this year, we started to see both the managed care companies complaining a lot about attrition in the marketplaces because they're saying the persistency of the consumers is very low. They come in for one, two, three months and pay premiums, get a lot of procedures and services delivered, and then they're dropping off either because the premium subsidies are not adequate, or the cost sharing subsidies are not adequate, and the out-of-pocket costs bearing the sticker shock is enormous.

On the hospital side, we're seeing a very troubling rise in the uncompensated care. You know, it's been happening slowly. HCA, the bellwether, reported that in the second quarter. Very worrisome. In the third quarter, we had some of their peers saying the same thing. They're not entirely saying it's because of exchange attrition, but if you try to kind of connect the dots across the two spaces we cover, seems like it's a fairly big driver of what's going on. And what that means for 2016, will we get the, will the stick work on the individual mandate to get younger and healthier people in, and will they be sticky enough through the remainder of the year? I think it remains to be seen.

**Paul Ginsburg:** Okay, you covered a lot of that. That was good. Let's talk a little bit about the co-op collapses. And I just want to ask you what are the most important factors behind the collapse of some of the co-ops, and how much of it has to do with inevitable barriers to new market entrants that are competing with large, established insurers, or have the risk corridor issues been more important?

There is a quote I wrote down from my former colleague, Deborah Chollet of Mathematica. And the quote was about how over the past 20 to 25 years all of the entry into health insurance markets by major insurers has involved acquiring an existing plan, rather than starting a plan from scratch as co-ops are trying to do.

So any perspective on what's the most important reason behind the failures of so many of the coops?

**Matthew Borsch:** Well, I think that partly it can be, maybe largely attributed to the circumstances the launch of the exchanges because the co-ops were oriented almost exclusively on the exchange business which initially by most carriers, whether they had experience or not with some exceptions was priced too low to begin with, and then you had the compounding factor of the Obama Administration's 11th hour decisions to allow grandfathering and versions of keep what you have which arguably led to some worsening dynamics for the risk pool and that made the pricing even less adequate.

And then finally, as has turned out, the risk corridors have been woefully underfunded, and that's maybe the third prong in this.
But, also, I think more broadly with respect to -- the co-ops didn't really have a lot to offer from the get-go. I mean, if you think about the co-ops as compared to, say, some of the new provider-sponsored plans, the provider-sponsored plans have emerged with their own assets, their own delivery system as something unique that they're offering.

The co-ops didn't really have an edge of any sort on which they could gain share except, perhaps, by virtue of the fact that they were not-for-profit. And then you consider the nature of the barriers to entry in this industry which I would argue are more in the form of the difficulty of replicating the network arrangements and the network pricing that established carriers have.

I think that is the number one reason for the dynamic that you referenced, Paul, where there really isn't any, with the exception, of course, of the coops, you don't see organic market expansion, organic market entry because it is so difficult to bring competitive pricing to the table.

The irony for the providers is that while on the one hand they may complain about the lack of competition among health insurers, to a certain degree they're responsible for maintaining the biggest barrier to entry in the form of the advantageous pricing they give to the larger carriers.

Paul Ginsburg: Actually, you know one thing I was -- it'd probably a great study which, perhaps is done by, I haven't seen it, of just looking at the relative increases in marketplace prices from 2015 to 2016 in different states and seeing how large a role that state's grandfathering, grandmothering policies can explain that because I just do recall now that California has had a very small rate of increase in 2016. That state did not allow the grandfathering, grandmothering and that may be the payoff for it.

Sheryl Skolnick: But I don't want people to lose sight of what Matt said which was the underpricing of the product in the first year. I mean, I was last here the year before last, and we had Carl McDonald here, Matthew Borsch here, … I learned a lot.

And so one of the things that you two were discussing was just how big a rate, and discussing with some enthusiasm how big a rate, jump from current commercial rates these folks would have to put in place in order to make money on the exchanges. And I think the numbers were at least 15 percent, if not more than that. And that's not what we saw.

And then the other issue that just as, as I sort of throw out there as question or not, just a point, by the time these folks had to figure out what their second-year bids were, they only had a couple of months of experience with the first year. And we talked about that then too, that the rate setting for '15 was not based on a full year of experience. These guys are insurance companies.

If you don't have claims experience, it's really hard to be actuarially sound in pricing your policy for the next year. One of the things United said on its most recent call was that they felt pretty good about their '15 and 16, more likely 16, rates on the exchange because they had started to see studies of just how underpriced product was, how high utilization rates were
relative to premium in the exchange product just before they submitted their bid and they goosed it up.

And if you didn't do that, if you weren't able to see that, then you're going to have yet another year of losses. And I think that that's a level of sophistication the co-ops may not have had.

**Paul Ginsburg:** Moving on to the spending trend outlook. We've had years of relatively low spending trends, particularly in Medicare. And this triggered an extensive debate about the relative importance of the recession and a slow recovery versus other factors that may prove more durable.

So from your perspective, what are the key factors behind the last few years of relatively low spending trends, and then what's your outlook for the next five years?

Ana Gupte: I'll take a stab at it at least from my point of view. So I think what you say is very telling in ways because you've seen this moderation in spending in the Medicare side of the house, and granted, even fixed income seniors may see a little bit of pressure enduring a recession because there is at least a little bit of out-of-pocket spend, but once you have, if you are on a Medicare supplement policy, you kind of feel pretty much covered there.

But the fact that you are seeing the slowdown in Medicare as well as in commercial, at least I believe that tells you that a portion of this is because of more durable structural factors than just the recession.

I think on the Medicare side, we've seen a huge increase in the adoption of Medicare Advantage, and whether or not one is in favor of the program, these are largely companies that are profit motivated and then we know that it's largely concentrated among publicly traded companies. It's gone from 1 in 6 to almost 1 in 3 people, seniors today, that have MA and they are much tighter at managing cost trends. They're dealing with reimbursement reductions. They're dealing with medical loss ratio floors, and they have been moving their product increasingly from PPO, which is more open network, to HMO. So I think all of those are fairly durable factors and should persist for a bit.

As far as the commercial side, I'm sure a portion of it is related to the recession. At this point you can see the trend, cost trend has kind of bottomed on the commercial side. The plans are anticipating very small upticks of 25 to 50 basis points. I don't think we'll get back to the 7.5, 8 percent type trend that we had in 2007 before the recession. You'll probably end up somewhere, I think, in the 6ish percent range, and it will remain persistently down as you have more out-of-pocket increases with high deductible health plans and a shift to value-base care also starting to percolate into commercial.

**Matthew Borsch:** If I could, I agree with Ana's forecast there. Adopt it as my own now. But I would maybe put a little bit more emphasis on the impact of the recession. If you look back at the way cost trends behaved on the downside, you really saw trends fall off a cliff in 2010. And it happened across commercial, Medicare, and even Medicaid to a large degree, which, I think,
given the timing you can reasonably attribute most of that to the aftermath of the Great Recession.

That happened a little more abruptly and more suddenly than we see in past economic cycles, but you've seen this trend in economic cycles in the past at least going back to the 1980s if not a little bit earlier than that.

And I think what you are seeing now is some gradual petering out of that recessionary impact, and that's leading to gradually rising trend in commercial and in Medicare, really, more utilization demand, if you will, and maybe it's counterintuitive if that's occurring in Medicare given that there is a lot less cost sharing there.

But there's even some academic evidence for a cyclical pattern to care seeking in single-payer countries, and there is, actually, cost sharing in Medicare, so it makes some sense that we would be seeing that.

The last thing I'd say on this is relative to where medical cost trend can go, and the reason that I agree with Ana on that is that I just don't think that there is, I just don't think we have the resources, payers don't have the resources to absorb a trend going up to a double digit level, for example.

I also think that some of the utilization of services at least with the existing medical technology that we have today is pretty saturated. So I'm not sure where that would come from unless it's from, you know, and this could be the answer, innovations, new innovations that we have yet to see in biotech or other areas of health care.

Sheryl Skolnick: Okay. So, again, I'm going to look at it from maybe the bottom up instead of the top down. One of the major things that happened from 2008 through today is the shift from inpatient to outpatient care across all payers, otherwise known as observations, so, essentially, delivering the same care but getting paid a fraction of what you were getting paid before. If that hasn't had a positive impact on cost trends, meaning pushing it down, I don't know what has, and that would go across the board.

So by the way, if you have Cigna and you need a hysterectomy, it's a 23-hour stay. It's an outpatient procedure if it's done robotically. You don't even need to ask, mother, may I. And you want to know why trend is under management? Because we have the technology, we have the innovation, and the payment just gets slashed. I mean, it's really rather amazing.

And on top of that, the pain management is such they literally can make you very happy to go home in 23 hours. That 24th hour is a killer, but in 23 you're rolling out the door. You're as happy as can be.

So there's a cost in terms of patient care or feeling, but they're very, very effective in managing care and Medicare in putting payment incentives in place now, otherwise known as rate cuts by saying, no. It's not an inpatient case anymore. It's outpatient. If you look at what some of the companies have done like Tenet, committing significant amounts of capital to get into the
outpatient business, the not-for-profit businesses have been leading that charge for a long time getting into the primary care businesses and getting into everything that is outpatient because they understand that outpatient is where things are being shifted to.

And the other thing that's happening now right away, I would say, is we're seeing a faster and faster pace of change, but broader kinds of changes in acute care reimbursement which as Paul said, is now a lot of money. We're spending $1 trillion. We need to control that. So it's a very significant effort on the part of entities like an Optum, which is part of United but not exclusively, like the innovation center at CMS, but not exclusively, across the board trying to find ways of reducing, spend to the absolutely minimum necessary level and getting patients out of the hospital which has significant implications here, and that's where I think the opportunity is. It's moving hospitals from filling beds to treating patients. And if you can do that, you'll crack the code on the next part of that $1 trillion that's going to get eaten away.

James LeBuhn: And I think on the not-for-profit side, I think they've been able to absorb those cuts. We've had a negative sector outlook and kind of expecting to see that impact at least on the not-for-profit side and we haven't seen that as much, and I go back to some of the trends. I think some of the mergers and acquisitions, and to be quite honest with you, I think the larger systems have just been able to operate more efficiently.

I mean, if one of the, one of the criticisms from the not-for-profit side is that they don't operate as efficiently as the for-profits. There are some social issues on that, but they've got strong balance sheets and you're also seeing lower leverage because they're spending less on inpatient facilities. And so they're able to adjust to that and they're moving more quickly. And so from a profitability standpoint, we've actually seen pretty good stability and profitability on the not-for-profit space.

Sheryl Skolnick: Well, when you have the for-profits trying to integrate acquisitions they probably never should have made, then you're not going to see a whole lot of margin improvement and efficiency at the local hospital level.

Paul Ginsburg: Let's talk about specialty drugs. That Hepatitis C drugs stood out because the number of patients who could benefit from them were so large in contrast to so many other specialty drugs that came before. Do you see more drugs like that coming down the pipeline for other conditions to be compelling, or is this just kind of a unique thing that we shouldn't be projecting?

Sheryl Skolnick: Well, I think that there are some -- I'm not a scientist, but just from what I see from the companies that we look at from a biotech and specialty pharmaceutical perspective, you know, there are some cancer treatments now that the Astra-Zeneca drug for lung cancer, for example, just got approved which could be a novel treatment. There are some other things like that that are treating some pretty serious diseases.

I think what was unique about Hep C was the patient population with Hep C was just so large and omnipresent across all of the beneficiaries among the publicly traded companies as well as the not-for-profits. So that it's just a broad disease as opposed to some of these narrower ones.
Paul Ginsburg: And there was a patient population that was basically inventoried.

Sheryl Skolnick: Correct.

Paul Ginsburg: As opposed to with cancer. You know, you'll do whatever you can when the cancer is --

Sheryl Skolnick: That's right. That's correct. And so I think that innovation and pharmaceuticals is absolutely continuing. The high prices of specialty drugs when they are introduced, of these true specialty drugs, will persist. And to some extent the first blush, the PBMs are going to have to deal with it. And then after that, they get smart and they get some interesting strategies to be able to kind of break the back of the pricing paradigm.

Matthew Borsch: If I could just add one more point to that.

Paul Ginsburg: Yes.

Matthew Borsch: And, of course, the interesting thing about the Hep C drugs is arguably at least they'll save money over time. I mean, that's yet to be seen, and, of course, it involves a very large, and in some ways which was not fully expected, up front costs that can be a shock. So one of the questions is what type of innovation do we get. Very expensive cancer drugs that add three months to life expectancy or something like these Hep C drugs that have a demonstrable impact?

Paul Ginsburg: Let's get into what are the PBMs and insurers doing to address this issue, and that I've seen that there's, you know, we had an era of tiered formularies, and now we're seeing exclusive formularies more and more. Any other facts on what's going on and what we might see?

Ana Gupte: Well, I think on the Hep C side just to add another point to that, it's been a large up front population. It's been a cure and it's a very short duration treatment with a limited prevalence, as opposed to a kind of a long-term treatment paradigm for a chronic disease such as cancer.

So in some ways I think the oncology issue is far more challenging. With Hep C, there was also a bit of, I guess, competition that came in at the last moment in the end of 2014 with Gilead and Sovaldi and the I.V. drug and the PBMs and the managed care companies that run captive PBMs got some relief out of it.

On the oncology side, I think it's a much harder nut to crack because you could have a stable of new compounds that could be lifesaving and everybody wants access to them. Anthem, has, I think, probably been most vocal and open about the pilots that they're doing with oncologists where there's a level of payment reform, if you will. There are up front payments to oncologists based on the number of patients that they have in their practice that are fairly sizeable, and that
direct them to stay within certain specified pathways, and the utilization is a little bit more monitored and it's an aligned incentive type of program.

Back to the Wall Street fears around drug pricing, I think kind of a corollary to that is there's been some fear that not only might we have congressional action as the tweets from Hilary and others might attest to, but CMS might get into more of a bundled payment pilot approach for oncology that is not voluntary and that could put a lot of pressure as well.

And, you know, I think the Anthem approach and then the CMS approach are ways to kind of control the utilization and maybe drive more pressure on the drug companies that are coming up with great branded options.

**Sheryl Skolnick:** So Anthem, excuse me, Optum just completed a five-year pilot of a new way to pay physicians. At the time they announced it, the payment for oncologists was combined with the price of the chemo drug, and they unbundled and they paid for the chemo drug separately and their chief medical officer was, unfortunately quoted at the time we're going to stop paying doctors to be drug pushers.

And as a result of that, they've completed the pilot. What they found was if you pay a doctor to spend time with their patient and actually treat their patient and manage their case, they do a really good job.

They found, actually, that oftentimes they, sometimes they used a more expensive drug, but they used the more expensive drug more effectively. And the cost savings for the program was at least 12 percent. I can't remember if it was 12 to 15 percent, but it was at least 12 percent over this period, and outcomes were better.

So the patients ended up having better outcomes, longer progression free survival. The costs were substantially lower, and this was because you pay doctor to do what doctors are supposed to do, and they're now drug independent. They can truly pick the medication that works best for their patient.

So as you start thinking about these bundled payment arrangements, what I worry about more in terms of whether it's drug spend or any one of these things is those unintended consequences of you think bundling is the answer for everything. It's not the answer for everything. You gotta be really careful to be precise and make sure you understand what goal you want to achieve, which is a healthier patient who costs the systems less money.

**Paul Ginsburg:** Yes, I'm glad you mentioned that. I think USC Schaeffer Center held a conference here on specialty drugs with the Hill in early October, and I had planned a panel on specialty drug bundled payments, and was really surprised in talking to people who were going to be on the panel and then during it the degree to which there is not, the emphasis was not on putting the drugs in the bundle. And that large opportunities for savings in hospitalizations.

**Sheryl Skolnick:** Uh-huh. Exactly.
Paul Ginsburg: Are there other technologies besides specialty drugs that you're aware of that are coming down the pike that might be important as leading to notably higher spending?

Sheryl Skolnick: I, for one, spend more of my time looking for new technologies that lead to notably lower spending.

Paul Ginsburg: Okay. Tell us about those.

Sheryl Skolnick: Because that's where I think we have to go so I'm trying to figure out if, you know, whoever builds that mousetrap.

It's mostly in changing behavior, as opposed to a technology. But a technology that is getting a lot of attention now is the richness of data that exists within not just managed care plans but also large hospital systems. And the challenge that one has is most of this data is in natural language. Okay, it's a patient record. It's a physician note. And all of this data is kept. Even if it's scanned, you really can't do much with it.

With some innovations out in the Valley, in Silicon Valley and in data science, which is actually now a really big career in case anybody wants to change careers and be really in great demand, data scientists are in huge demand right now. And there is this language or a process, I'm not sure what it is, it's, I guess, a combination of both, called Hadoop, which allows you to do natural language processing extraordinarily efficiently and very quickly.

So this is the enabling technology that's going to dramatically affect the cost of health care because now you have this big database that you can build of records and experience of how patients are treated, what actions lead to better outcomes, what actions lead to worse outcomes that you can now eventually implement as a next generation best practice so that you can use the analytics to change behavior to reduce cost.

So that's where I see a lot of the innovation coming is from data from analytics as opposed to from clinical practice.

Matthew Borsch: And Sheryl, just to build on a point you made there, which is also though the technology that's enabling more and more things to be done on an outpatient basis outside the hospital. In many ways that's process innovation. It's more than technology, but that's clearly a source, has been a source of innovation over the last decade, if not longer.

Sheryl Skolnick: Right. And part of that is the anesthesia, the improvements in anesthesia and pain management and just our willingness to take the risk of not having a big operating room and big emergency staff standing by while we have a minor procedure.

James LeBuhn: Well, and Sheryl, I think the whole idea of interoperability, I mean, in the not-for-profit side we these large systems that are substantial investments and epic consumers, which is great as long as you're within that network. But if you move outside that hospital network --
Sheryl Skolnick: It's a problem.

James LeBuhn: -- we've all heard those stories, and we've got to go in and have imaging done and go through everything, go through those same steps. How many procedures are done that don't need to be done, are redundant, and that's a hot button issue. I'm not sure where we stand. I think some of the vendors obviously are pushing back on developing interoperability because it serves --

Sheryl Skolnick: Serves (inaudible) reasons.

James LeBuhn: Right.

Sheryl Skolnick: Yeah. It's the gilded cage -- if you're not.

Paul Ginsburg: Probably about 15 minute we'll be taking our first break so if you have questions this will be the time to start writing them down on the blue cards.

What about labor costs for providers? Is this an issue? Are wage rates going up? Are there serious shortages?

Sheryl Skolnick: So I'll take this. Well, whether there are or they're not, communities pay for it. Okay, their stock got whacked as their earnings collapsed because they were the second person who said labor costs going up or wage pressures, not quite wage pressures, but labor costs causing an earnings missed. The first one was HCA.

And then it was just stunning. All of a sudden, as soon as the conversation started, everyone sort of chimed in and part of it is because when HCA and Community pre-announce really bad news, everyone else knows they're going to get asked so they might as well mention it even if it's not a problem. And for some of the providers it wasn't a problem.

But, clearly, what we're beginning to see is that if it's not actual nursing wage pressures, it's physician, employed physician pressures where the hospitals have gone out and acquired a lot of practices, employed a lot of physicians, and those physicians aren't nearly as productive as you thought they would be, especially since their patient admissions aren't going up, and that's a whole 'nother story.

And then the second issue is that as you get economic recovery in some markets, you know, the nursing pool is a little bit older. They tend to be second wage earners in families, not exclusively, but one of the beauties of being a nurse is you can go in and out of the labor pool. And so we're beginning to see some signs in some hotter markets in Florida and some other places where the nursing pool is beginning to shrink.

On the other hand, a lot of what we saw in the quarter was self-inflicting wounds where on the part of HCA they didn't handle their graduate nurses who come on in May and June particularly
well because they have to be oriented and trained and cuddled a bit to give them the confidence to go forward because they're a little hard to handle.

And we've seen this before. Actually Tenet had that problem a number of years ago and it's interesting that HCA is having it again now. So that's one issue.

The other issue is if you have unexpectedly high volume, then you pay contract labor rates. Well, why do you pay contract labor rates? Because you have too many open positions. Why do you have too many open positions? Because you're not paying enough money.

So at the end of the day, they can tell me its company-specific all they want. I find it very hard to believe that when you see this confluence of onesie, twosie factors that we're not seeing the beginnings of an underlying trend of a tightening labor market, especially for nursing, and the inefficiency of owning physician practices on the other side weighing heavily on labor costs.

James LeBuhn: Yeah, I don't have a lot to add because I agree with most everything you said. I think on the not-for-profit side, particularly in the Medicaid expansion states you've seen an increase in the need for nurses and staffing there, and I think that that's had an impact. You know, generally, when we're talking to not-for-profits, they kind of try and downplay that issue, but that's one of our bigger concerns going forward is that over the last few years, the ability to manage salary, wages, and benefits costs have been something that's been beneficial for the sector and they think that those wage pressures now are going to, are going to be more difficult to handle going forward.

Sheryl Skolnick: Yeah. It was unusually helpful in 2009.

James LeBuhn: Uh-huh.

Paul Ginsburg: This is an off question here. But, you know, you hear so much about wellness, and both, many large companies about the potential of wellness, but, also,(inaudible) a lot of skepticism as to, you know, is this really a pipe dream, and some research showing, well, if you're going to save money from wellness, you need to have a total company commitment and it's not easy. Do any of you have perspectives on whether that's an area of opportunity for, say, employers?

Matthew Borsch: I think the jury's still out on that. The evidence to the extent that there is evidence is mixed. But it does seem to point what you just cited which is that in order to get strong results, a really strong effort is needed to move the needle, and it's not clear that the majority of companies have the, have the will or the resources to really engage in that type of companywide effort and the complications that that would bring.

Paul Ginsburg: Other thoughts on it?

Sheryl Skolnick: So the one company that did engage in wellness oriented behavior was actually United. Remember? And they were in the fortunate circumstance of first of all being a managed care company and being able to experiment on their own employees, and they did it
quite effectively and efficiently. But what worked for them? They reduced the employees portion of next year’s premium by a couple hundred dollars a person for every person who achieved their health goals in a year. And there's nothing that talks like money.

James LeBuhn: And my sense is just that. Is that the incentives, the financial incentives have never been great enough to really change behaviors.

Paul Ginsburg: Let's get to some audience questions for a bit. I've got some cards here. I don't know if there are microphones set up. Okay, so people want to go and ask Do you anticipate that some ACA exchange plans may become de facto high-risk pools and unravel due to the high premiums and dropouts from healthier consumers?

Ana Gupte: I'll take that one. So my observation of what's going on right now with the exchanges is that there's dichotomy that's happening with the Medicaid plans and what the diversified large insurers are observing as far as adverse selection and what their profit margins look like.

And if you (inaudible) as a Centene, and Molina, and Healthmed, they will tell you it's because they are better at pricing and they did a better job of pricing appropriate with the health risk, but that seems really hard to believe that United and Humana and all did that -- do that so well.

So I think that the lesson to be learned to some degree, we'll have to observe what happens, is that the premium and the cost-sharing subsidies for exchange eligible enrollees up to, say, about 250 percent of federal poverty level which is where the Medicaid plans target their efforts in the marketplaces because they want to make sure that they address churn between the Medicaid population and then they get part-time jobs or whatever, and exchanges is likely to be functional marketplace.

They also have a better cost structure because they're building it off of Medicaid networks in low-income neighborhoods. It's also their way of insuring that people that don't make above $50,000 and are expecting to overuse and have inadequate subsidies enter that marketplace.

Between kind of 250 percent or 300 percent of federal poverty level to about 400 percent toward the end of that exchange spectrum, that market right now looks broken with where the consumers are relative to what they can afford. And I don't know whether any of you are thinking about or how that might play out in terms of any legislative action or whatever, but it's quite possible that that portion of the market, I think, ends up becoming more of a unstable, high risk pool type marketplace.

Paul Ginsburg: Actually, let me just do a follow up to that. To what extent in that 250 to 400 percent where the subsidies are modest, we're talking about what's really a market failure. We talked about the fact that where health care has become so expensive that the subsidies just are not great for that population, and that this is a, the problem is far broader than the exchanges.

Matthew Borsch: Well, it's both, right? I mean, it's both a market failure or a policy failure, if you will. The offer to consumers in terms of the level of subsidy is, and the out-of-pocket cost
in the end is just, is not great enough. The out-of-pocket cost is too much relative to the perceived value that's brought to the consumer from high-deductible plans, most of them are high-deductible plans, for pretty much everyone except for those with immediate care needs which is, you know, the danger of where we're spiraling towards.

Of course, having said that, we're going into a new year, into a new tax season. The penalties are moving up and we don't know what the impact is really going to be at the end of the day. I think there's, certainly, cause for concern that there’s not going to be enough to repair the risk pool, but we'll see. We've got another chapter to go here.

**Paul Ginsburg:** Got a question. How do insurers view telehealth and telemedicine? Does it reduce or increase net spending? Do they require enrollees to pay high cost sharing. Do they think it improves the outcomes?

**Matthew Borsch:** If I could. I don't think that what we've seen so far is moving the needle enough where the companies are talking about it and seeing it have material impact. Having said that, it stands to reason that it could have a real cost lowering impact if you think about as being something somewhat akin, perhaps, to the shift to outpatient on the hospital side. And, clearly it has the potential to be that, but is not there yet in terms of the scale, and part of that, part, I don't want say all of it, but a piece of that relates to, I think, reluctance on the part of insurers to reimburse for those encounters at rates that would be adequate to bring widespread provider participation.

**James LeBuhn:** I think that's a good point. My sense is, is that telehealth, the incentives have to improve for the physicians. I think they tend to be a bit more resistant just like you said. Until those incentives get more aligned, I think it's going to be more gradual.

John Graham: John Graham from the National Center of Policy Analysis and Forbes Magazine. And my question is about provider-based plans. I've read anecdotes, but I haven't seen good measurement that they are increasing subsequent to the ACA. And I'd just like comments on will they succeed. My understanding is that's it's very hard to get the incentives right and that has historically been the problem. Will they take market share, in which segment will the take market share, or will they fail?

**Matthew Borsch:** If I could just offer an opinion on that. Of course, you already have some provider-based plans, if you will, that are successful and have been successful for a long time in Kaiser, if you can use that one as an example, Inner Mountain, Geisinger, and so forth.

What has changed is the increasing availability of health plan members on a retail basis. You're moving from the exchanges, from Medicare Advantage, maybe from private exchanges if those take off or they haven't really thus far. Where narrow types of provider-based plans can go after those members and make an offer that works for them and their families, that really probably wouldn't work for a group sponsor that is trying to represent a geographically and otherwise diverse population.
So to the extent we keep moving in that direction for more and more retail, there are going to be more and more opportunities for provider-based plans to make a viable offering, and some of them will succeed and thrive. Others which maybe still, you know, don't have the right (inaudible) or are at the end of the day oriented around filling beds and driving utilization, rather than coupling that with also needing to have an efficient cost of care. Those ones, obviously, are less likely to succeed.

Sheryl Skolnick: And so a couple of those examples. For example, North Shore LIJ has been very been very active in building their Care Connect product, and that's a very interesting one. One of the things that I would observe about where we see the provider-sponsored plans perhaps being a little healthier is where the provider has a lot of concentration of not only services in the market that will be in demand by the population it will insure, but also market share across all of those services. Because if you are a really significant player in the market, and if you are, and I think Matt hit it exactly, if you are understanding that the goal of the exercise is not to fill a bed, but to provide the right care at the right time at the right place, at the right cost, if that's your goal, then you're more likely to succeed.

So what we're seeing on the for-profit side is very limited participation. I think all of the hospitals with maybe the exception of LifePoint has a managed care provider-sponsored plan in a market someplace, but they're very special cases. HCA is pretty adamant. We're in the hospital business. We're not in the managed care business, although they have one or two here or there because you sort of kind of have to.

But, again, HCA is still in the business of filling beds. They haven't moved off that. They just figure that everybody else is going to exit and they're going to be the ones left standing because you are going to treat trauma patients in hospital ORs and beds, and they want to be the ones to do it. So it's a little bit, that's a little bit of a different play, but it's still vulnerable.

With homage to Carl McDonald, I think he was the one who said, look, it's taken the managed care companies 30 years to figure out how to manage risk and they still haven't gotten it right. The hospitals have no business being in the insurance business. I think he said that here a couple of years ago. It's one of my favorite all time quotes but that's exactly right. It's a very dangerous game.

Paul Ginsburg: Yeah.

James LeBuhn: On the not-for-profit side, I would echo what Sheryl said. You know, we're seeing -- there are certain not-for-profits, Presbyterian down in New Mexico, again, it makes sense if you've got the inpatient, you've got the outpatient. You're aligned or owned enough physicians where you have enough market presence in your market where --

Sheryl Skolnick: Yes, Henry Ford in Detroit, yes.

James LeBuhn: You know, where you can begin to look to take on that risk. I think on the not-for-profit side what we're seeing is many people are interested in it. They're dipping their toe in there, looking over the long game. As you see further consolidation, I think the concern
on the provider side is well, if we do a better job of providing the right care in the right place at a lower cost, all that's going to do is those benefits are going to go to the employers and to the insurers. So we better get into that game so, like a Kaiser, we sort of align it if we do a good job. We want to own that premium dollar so the benefit that we can bring we can keep.

**Sheryl Skolnick:** They have to stop being hospital companies and they have to start being health care companies.

**James LeBuhn:** Exactly.

**Sheryl Skolnick:** It's sort of this concept of a margin indifferent healthcare holding company which is sort of the Kaiser model where you don't care where the care takes place so long as you own the patient and some of the profits stick to you.

**James LeBuhn:** And I get the sense, Sheryl, that the not-for-profits, again, because they don't have to -- they don't have quarterly calls. They don't have earnings targets that they have to hit. They generally have very strong balance sheets, are in a better position. They've been further ahead of the for-profits in terms of dabbling, kind of dipping their toe into some of these different areas and maybe looking to develop a health plan. Whether they do that on their own or whether they do something on a joint venture basis with some of the --

**Sheryl Skolnick:** Yes, my sense is that they started worrying about standing in the two canoes of fee-for-service and fee-for-value a lot sooner than the for-profits did.

**James LeBuhn:** Yes.

**Sheryl Skolnick:** And so, yes, they may be ahead of the game. The other thing is the for-profits don't like to talk about anything that isn't fully baked. So it's sometimes hard to know exactly what's going on. But I think for most of them, you know, where I would expect to see any of these sort of innovative things going on would be interestingly, Tenet. Potentially in some of the Duke LifePoint facilities and possibly -- and in certain of the HCA facilities but it is not broadly based. They can't risk it.

**James LeBuhn:** Uh-huh.

**Paul Ginsburg:** Yes, something that Matt said motivates me to expand on it that and when we first saw hospitals start health plans was the 1990s. And I think the expectation was that there were going to be a lot of HMOs with narrow networks that they would contract with on the risk basis and (inaudible) offer those plans. And then, when that all blew up, in a sense, the market for a hospital-owned health plan disappeared too.

And some of the hospitals were able to run the plans well enough to keep them or to sell them for a good price to an insurer. But it seems now that the world is coming together again where between public exchanges, private exchanges, Medicare Advantage, there really are -- is an audience to recruit to commit to a hospital's delivery system.
I think we should have time for a break. Some of the questions I have here that I couldn't get to are on the second half of the meeting's content so I held them for that. We'll see if maybe we can to the next Q&A session. So let's return in 10 minutes. Is that it? Yes, 10:45.

(Recess)

Paul Ginsburg: I'd like to reconvene our meeting and some of the regulars in the audience have noticed that things are out of order and there's a reason for that. When I used to do it before, I used to have health plan, managed care questions here then provider questions. And the result was we would have half the panel with nothing to say for half the meeting. So they're all mixed up.

So yes, someone asked about alternative payment models, ACOs, that's coming soon. I'd like to begin with Medicaid expansions. And first question is if you look at the waivers granted to states in conjunction with their expanding Medicaid, what can be gleaned about potential changes to the nature of the partnership between states and the federal government from Medicaid?

Ana Gupte: I'll try a crack. I'm not sure exactly what the question refers to but it's been pretty stark with the waivers that are granted and I think the New York Times had this really very, you know, very visually powerful map of what's happening among the red states and the blue states and where the lines of percentage of the uninsured lie.

I mean, clearly, within Obamacare the Medicaid expansion has been the most successful and to the extent that these states have been given leeway to seek a waiver and not participate, they are likely to continue to do that. I think for us on the street, we are probably, at least I was, you know, initially about Florida in particular expanding Medicaid and it looks like even that seems to have stalled. And we'll have to see what happens after the elections and as far as Texas goes, I'm not that optimistic even, you know, after the elections. And those are the two, the biggest states where particularly the for-profit hospitals that we all cover have a geographic presence.

Sheryl Skolnick: So I have a very cynical view. I doubted that Florida would expand although there was a moment of brief hope when you thought that maybe the Arkansas plan was the solution, the politically acceptable solution in Florida. And that lasted for about three split political seconds. And Texas ain't never going to happen.

It's -- the probability of Medicaid expansions, I think, diminishes as we get closer and closer to the fact that the government's 100 percent subsidy of the additional cost drops to 90 percent in just a few more years and goes, you know, away to a greater extent after that. So the time to really take advantage of the federal government's largesse from a state perspective actually has passed, in my view, to a very large extent.

And I've actually cautioned some of the hospital companies who talked very optimistically about future expansions on the calls, on the third quarter conference calls, as they were holding out some measure of hope to investors that when those subsidies go away, you know, we've been through, for example, an FMAP cut that, you know, we had that increase in the recession
and then the 10 percent went away. And that was absolutely brutal in terms of what happened to Medicaid spending and hospital reimbursements. And so I don't think anybody really wants to live through that again either from a state political perspective and a state governance perspective or a hospital perspective.

I think the CMS really tried to bend over backwards as much as it could to facilitate the participation in Medicaid expansions as it should have. And pretty much would have approved anything reasonable and for -- as for example, something as quite interesting and innovative as the Arkansas plan.

Now we're at risk with the election in Kentucky, for example, a plan that was implemented by a governor overriding a legislature with a new Republican governor overriding his predecessor. So if anything, I think we're going to take steps backwards in Medicaid expansion, not forwards and just a footnote on Texas and Florida. 20 percent of the state of Texas remains uninsured as of the last Kaiser Foundation survey.

I think before, when we started, it was maybe 23 percent of the population in Texas was uninsured. So virtually no progress made there. It is a big state and three percent is still a lot of people but virtually no progress made there. Wall Street is amazing in its naiveté and willingness to invest without knowing what it's doing.

There were many people who owned hospital stocks who were shocked to find that the ACA didn't cover every living soul in America with insurance. That magically everyone would be covered and so when HCA came out and said, yes, you know, our uninsured volumes are increasing, they're up 8, 10, 12, 13 percent depending on the moment you looked at it year over year. Guess what? There's still a big chunk of the population that remains unchanged and with very little prospect to be getting insurance anytime soon.

Matthew Borsch: If I could speak up on behalf of the naiveté. I just with a slightly more optimistic view on Medicaid expansion and this is seats of the pants but, you know, first of all, if you think about what might happen let's say if the GOP wins in November, I would think you will go to a more federalist approach on health reform where states that have already expanded Medicaid will be allowed to keep that, if you will, because I think that's going to be pretty difficult to unravel. And you might see something like block grants for the states that have wanted to stay out of the Medicaid expansion.

At least that's one possible outcome. On the other hand, if the Democrats win, you know, I think you will see more states fold into the Medicaid expansion than not. I mean, the comments recently, I think it was from the Alabama governor, Republican governor, expressing some level of interest in pursuing the Medicaid expansion. That was sort of --

Sheryl Skolnick: Yes, that was interesting.

Matthew Borsch: -- a crack in the iceberg. Yes, I agree with you we'll have to watch Kentucky. So that's my view on the situation.
Sheryl Skolnick: So when you say the Democrats win in November of this coming year, a year from now, do you mean not just the White House?

Matthew Borsch: Well, I can try to put it in simplistic terms. It could be more than the White House or maybe it's, you know, the current configuration in Congress with Hillary in the White House.

Sheryl Skolnick: Yes, I think nothing gets done on health care. I think nothing gets done, that's what I'm saying but that's all right.

James LeBuhn: Yes, I've got to agree with you, Sheryl. I mean, if you look at it, there hasn't been a political penalty to pay at the state level. And in fact, the GOP has taken more of the legislatures and governorships by not expanding Medicaid. So there hasn't been a political penalty at play and I think, like you said, Kentucky's going to be very interesting to see what happens there. You know, whether or not they can take away those benefits and what the political price is to pay there if there is any.

Sheryl Skolnick: This is somewhat of an aside but I was amused when conservative critics of the Supreme Court criticized Chief Justice Roberts soundly for his support of the ACA and what they don't understand is that he did more to eviscerate the ACA by allowing the Court to not enforce the Medicaid expansion than anything else he could have done. Because that was -- it's -- A) it's the only thing that's working, B) it was the simplest approach to insuring the most people and C) it's led to the persistence of vast numbers of people being uninsured.

Ana Gupte: And I guess from me back to all of you that are on the Hill, with the Texas Medicaid waiver and the Florida low-income program, why did CMS and HHS not take a harder line around limiting that funding? I mean, we have two governors obviously come in and threaten the lawsuits and so on but is there actually any teeth to that? And why couldn't more -- I think some of the Medicaid managed care CEOs seem to think that a harder line should have been taken and, you know, they could have driven them in.

Paul Ginsburg: Yes, well, probably as a parallel to the grandfathering/grandmothering of existing individual plans. In a sense it meets a short-term political need even though it sacrifices the long term goal of the policy.

Sheryl Skolnick: That's part of the frustration with CMS is that there's not a persistence in a line. They draw a line in the sand and then, they very quickly erase it and step back from it.

Paul Ginsburg: Yes. Let me ask about kind of a basic question and maybe, Jim, you should start this. And actually, you know, Sheryl might also. In those states that have expanded Medicaid, take us through how this affects the bottom line of hospitals. That they're going to have more paying patients but they're going to be paying at low rates. Okay?

James LeBuhn: You know, what we've seen is the main benefit on the not-for-profit side has been a very sharp reduction in charity care. I mean, certain of the, you know, there's a large portion of this population that's now covered under Medicaid so at least they're getting
reimbursed. I mean, those people were presenting themselves at the emergency room and coming in for care so that the hospitals were providing that care but not getting any reimbursement.

And so what we hear quite a bit is that, well, at least that now I'm getting reimbursed for that. I think the challenge going forward is providing that care. Do you have enough physicians there from a primary care standpoint then to begin to manage that. So I think the initial impact has been very positive. At least they're getting reimbursed. You know, the next step is okay, how do we manage this population? Because there you really do need to manage it because if you just approach it from a fee-for-service basis, you're going to lose money on higher volumes there.

And so I think the trick is going to be how do we manage that population to keep them out of the emergency room going forward and getting care when it's an acute need.

Paul Ginsburg: And whose job is that going to be, that management job?

James LeBuhn: Well, I mean, what you're seeing in many states is this movement towards managed care Medicaid and so the -- depending on, obviously this is going to hit different health care systems differently if you've got a large managed Medicaid population, again, your incentive is to work with those managed care providers to really provide that care in a more cost-effective setting, medical homes, working on those chronic conditions. I think there's a real incentive for the not-for-profits.

Paul Ginsburg: So if the ACA perhaps by expanding numbers, led to an acceleration of this movement by states into managed care for Medicaid?

James LeBuhn: Yes.

Sheryl Skolnick: So let me just help some folks with the math of why you would take a low-paying Medicaid patient every single day over a no-pay patient. Okay, just saying it that way, low pay is greater than no pay.

Paul Ginsburg: Okay. Those states, in those states conducting demonstrations of managed care for dual eligibles, what's your sense of the takeaway so far, if any?

Matthew Borsch: I'd say unfortunately underwhelming thus far. This was something that Wall Street viewed a few years ago as the next big thing and maybe it will evolve to that from the standpoint from a growth opportunity given the dual spending north of the $300 billion per year with 90 percent plus or maybe we're a little bit below this now but 90 percent or so not in managed care, unmanaged.

That said, the demonstration programs have gotten off to a slow start and the numbers have been disappointingly low. Part of that is related to, I think in many cases, a higher than expected opt out rates reflecting the inclination of providers who serve that population not wanting to see managed care make inroads, whether that's right or not. The problem then is
when you have numbers that are as small as they are in many cases. It's not clear that the demonstration programs can actually demonstrate what they need to which is real cost savings. So the jury's out. We'll see.

**Paul Ginsburg:** Yes, you know, Matt, I wonder if this could be a factor. I understand that the plans doing the managed care in that demonstration are Medicaid plans. If they instead had gone to Medicare plans, perhaps could that have helped on this opt out issue as far as something much more familiar and with broader networks for the beneficiaries?

**Matthew Borsch:** It's a reasonable question. I can't really offer a good opinion on that one.

**Ana Gupte:** Well, I think -- I don't know that it's just Medicaid because United and to some degree Aetna and Humana and others are also participating and have won some of the integrated dual contracts. I think, and just sitting from where I sit, I feel like the challenge has been when you compare why the adoption of Medicare Advantage and seniors liking Medicare Advantage, it's so different than the experience in public exchange marketplaces and in duals.

It feels like the beneficiaries don't have an adequate incentive in the dual eligibles and in exchanges to continue to participate. And the opt outs are particularly severe in California and they're the providers of, literally in some cases, very large health systems have taken out full-page ads in the newspapers pushing back and advising the beneficiaries not to be in these plans.

And, you know, it's not just Molina and Health Net there. I mean you do have commercially oriented plans as well. So it may be a little bit of it is a network but a large portion of it is is there any cost savings? Is there any financial incentive for them to stay? Why wouldn't you just be in fee (inaudible) in manage Medicaid and Medicare and stay in your institutional nursing home forever and no one's trying to move you into some home setting with social work and all the complexities associated with that.

**Paul Ginsburg:** Good point. Next topic is alternative payment models. I'll begin with asking about the provider perspectives on ACOs and bundled payments. So if someone would characterize how hospitals and physician organizations perceive ACO and bundled payment contracting in Medicare and in private insurance?

**Sheryl Skolnick:** I'll be happy to start with that. So I think the reactions range from embracing it from most and among the most innovative of the provider groups to fearing it greatly and treating it like something that is really poisonous to their business model because it always results in fewer heads in beds.

I think that the first year participation in the ACOs and the pioneer ACOs and some of the others, you know, there was some eagerness and some enthusiasm among the providers to try something new, to have the ability, perhaps, to capture some of the managed care margins that existed at the time by managing population health.

What they found was that when the hospital is at risk, you know the only way the hospital is going to do well in an ACO is if they can gain market share because they’re going to lose
patient days if the ACO is going to succeed. And as far as I know there was only one Medicare -- the original Medicare ACOs that actually gained market share and that was Memorial Hermann. All the others not only lost market share but they also lost volumes in order for the ACO to be successful.

Now that should have been a trumpet sounding for the hospitals that the way of the world is moving them from filling beds being their operating paradigm. That's not why a successful hospital is going to exist anymore. They're going to exist because they run the ACO and some of the margin of it sticks to them and they're margin indifferent because they have a vertically integrated network or some other strategy to approach this.

On the other hand, there are many ACOs being formed by organizations like Optum and Cigna and Aetna and every other health plan in creation who are specifically excluded from the Medicare ACOs initially. So the one entity around that gets how to manage population health and risk at all was excluded from the Medicare design.

Medicare, I'm sure, had their reasons. Congress actually had their reasons. So what you're now seeing with the ACOs is that they're becoming very, very popular being spearheaded by managed care rather than providers where they're being -- they're really ACOs with the physicians and to a lesser extent the hospital systems and the other provider networks because we all understand that the one who controls utilization still is ultimately the physician.

So those -- if the rate of proliferation of those, I think this year Optum was looking to establish on top of the 500 they had last year, another 500 or so this year. They're at about 750 today so they're getting closer. You know, that's a lot of ACOs. I mean, there's many markets and there's many individual markets where they want to do that but there's a lot of ACOs just at Optum.

So provider groups view that -- facility-based provider groups view that with trepidation. Bundle payments so the Federation of American Hospital Systems basically told Medicare you've never done anything mandatory. You can't do comprehensive care for joint replacement because it's mandatory is a major policy change. You can't do it. Last night they said, oh yes we can. And they're doing it, okay?

So putting in mandatory bundle payments for hips and knees which by the way is probably the easiest procedure to do it for because the process is so standardized and the outcomes are so measurable, right? Roll in, walk out happy. And the smart hospitals are getting behind this. They're understanding that this is the way of the world so you'd better get your practice in soon which was why the BPCI pilot, the model two pilot, has increasing participation in the pilot to this day because you'd better get smart about how to operate under bundle payments where you're responsible for a long length of the episode of care post-discharge.

And again, whether it's being financially incentivized to change the operating model and the paradigm of running the hospital or pressured by competition or lack of anything else to do to keep your doors open, hospitals are beginning to figure out that they need to embrace and I think the for-profits have been way ahead of this, they're beginning to embrace this notion that
we are going to be at risk. We'd better learn it soon and even though we're going to push back and we're going to fight, the hospitals will be all right because they're the ones who are getting the money first.

If the physicians were the ones getting the bundled payment, the hospitals would be toast.

James LeBuhn: Yeah, I was going to say I think on the Medicare ACO side, I think that one's, you know, we've seen there's just been what were there 32 pioneer ACOs and I think they're down to 12 now and it's been a lot of dissatisfaction in terms of the attribution. You don't know who you're attributed. The information coming back from CMS has been badly lagged and so and there -- on the not-for-profit side, there's been a fairly substantial investment in order to move the organization to manage that care in the ACO.

And they just don't -- organizations haven't seen that payback. I think also that there was very little, if any, risk adjustment to that patient population that you were getting. And so from a financial standpoint, I think on the not-for-profit side, I mean Dartmouth Hitchcock who has been one of the leaders said enough which it's not worth it to us.

On the commercial ACO side I think there's been much more embraced. Now it depends on who you are in your marketplace. If you're a market leader and you've got good alignment with your physicians or you've got a large physician group, I think there's more acceptance. If you're a traditional standalone hospital with a community-based physician group, I think that there are much more reticent about that.

I think this move towards bundled payment and the move towards ACO, again, is going to be another thing that's pushing consolidation in not-for-profit space in order to have that size to be able to manage that care through the continuum.

Sheryl Skolnick: Yes, and just to follow up on a couple of things. One thing is, I think, when we talk -- when I think about how consolidation will affect, as a result of all the payment change, and the payment change is massive and it's broad and it's complex at the acute care level and throughout the system. So if there's one underlying trend that Wall Street has missed, it's the pace and complexity of payment change that's going on right now from the private and public sector.

But as far as the consolidation we're going to see, it's going to be consolidation in the form of closing hospitals not consolidation in the form of big mega mergers in the space. Hospital beds are either in the wrong location and must go away and be shifted to the right location or just simply there are going to be too many of them.

The other industry that we need to talk about here is post-acute facilities because it's not just hospitals. The Lewin Group did an assessment study for the BPCI after 1 quarter's worth of payment and I looked at the preceding 12 quarters leading up to it but really focusing on the preceding eight quarters and then, the 1 quarter of payment. So this is one quarter's worth of data and while that's a little bit risky, so many of the model two hospitals chose hips and knees
that there are more than enough hip and knee cases for the numbers to be statistically significant.

And they are compelling. So on a risk-adjusted basis, the skilled nursing facilities saw the percentage of cases at discharge going to SNFs go from 66 percent to 47 percent. Okay? From 66 percent of hips and knees going to SNFs dropped to 47 percent. Obviously, that was statistically significant.

Home health companies saw 25 percent of discharges coming to them go up to 34, almost 35 percent on a risk-adjusted basis. So what does that tell you? It tells you some people went home directly without additional care or with outpatient care which wasn't measured. Some people ended up in home care and, you know, moving from 24 percent out of every 100 cases, 24 going to 35, those 11 cases make a big difference in home health. But for a skilled nursing facility to go from 66 to 47, that is huge.

Layer on top of that you have LTAC (long term acute care hospital) payment criteria changing. Layer on top of that you have old other, you know, we have value-based payments going into home health. You have hospice payment arrangements changing, the view of the post-acute care from a reimbursement perspective changing a lot. Then you layer these bundled payments on top of everything. There is going to be very significant shortfalls in heads and beds in post-acute. That's our prediction, my opinion. And significant growth in home health but the amount of that falling on the bottom line will depend upon how well they do under value-based arrangements.

Paul Ginsburg: Yes, that's very bad news for the companies you cover.

Sheryl Skolnick: Well, I don't mind a little bit of bad news.

Paul Ginsburg: But it's going to be very good news for policymakers if this payment approach is having real change.

Sheryl Skolnick: And it did. And I expect it to on a very large scale.

Paul Ginsburg: Yes. And talk to me about the capability, I mean, you know, there was a simple thing you could do for joint replacement of just moving people from SNFs to home health. And that made a big difference. What about other cases where you just need the SNF or the home health to perform in a more of a population health strategy, not hold them all for 21 days so is there much capability in the industry of being a real partner for hospitals?

Sheryl Skolnick: I think there's some hope there. I mean, the one -- there's a couple of entities from the publicly traded side trying to do that and certainly one of them is Kindred who in 23 markets has an integrated approach of everything from LTACs to ERFs to SNFs to home health. And part of the challenge there is the math doesn't work, right?

If you're getting $600 or $700 a day in inpatient SNF and $150 a day under your Medicare rate, implied $150 a day on your Medicare rate for home health and you do that math and you know
they're not going to make money, right, when they shift from one to the other. So there are some issues there.

But as an integrated provider in 23 markets, they should be a very good partner for the hospital. HealthSouth, for example, in their inpatient rehabilitation facilities and generally with rehab because it's easy to measure outcome, can show you really good solid, significant data over a long period of time that if you send a complex case to them for 13 days they will save you money because that patient will not bounce back. So there are some partners out there. They've now acquired home health. They are focusing on overlapping their ERFs and home health in the same markets.

They're going to stay far away from SNFs. They're going to stay -- they've already gotten out of the LTAC business and they're picking their spots. But it's going to be up to the hospital to work with either some notion of a convener or something or build it internally to be able to pick the right partners and be able to discern what is true outcome data and we'll call it a repeatable process versus anecdote.

Paul Ginsburg: Yes.

James LeBuhn: And so it seems to me in the post-acute space there's probably more pressure on heads and beds in terms of skilled nursing. And you're probably going to see a greater divergence of winners and losers. There's just so many nursing homes that care is getting taken out of there and they're going to have to prove their ability to help manage that care which means lowering that cost.

Sheryl Skolnick: Let's start with managing the cost. I'm not sure they have any incentive to do that right now other than their own profit margin because it's not really even a case right sort of. But the other issue that we're facing with the skilled nursing, because of site neutral payments up top for LTACs and for IRFs (inpatient rehabilitation facilities), they're trying to increase their level of acuity so that they can fill the beds with the patients that they're not going to compete with in the LTACs.

The LTACs are trying to compete with those higher acuity SNF patients and go for the per diem rather than have empty beds. So what it tells you is there's, in some sense, there's too much facility-based capacity or the facility-based capacity that you have has to be reoriented in terms of what patients it really is optimal to treat. And that's going to be an extraordinarily painful process.

Paul Ginsburg: Good. What about, I guess I was surprised when the -- I haven't seen the details of the joint replacement rule that came out last night but the -- just in the proposed rule, I was surprised that they were putting the hospital at the center of this. And any comments about why they did that, whether they're going to limit the potential by doing it?

Sheryl Skolnick: So I don't know the answer because I'm not at CMS. But I could guess that they had really, really, really good data from the BPCI model two because that's where they got all the participation. And if you're going to put in place a mandatory pilot in a large number of
markets affecting a significant number of beneficiaries, you'd better have data at your back. And that was the model in which the hospital was getting -- was at risk with the anchor stay and directing this.

**Paul Ginsburg:** Yes. Other comments? Are many delivery systems deciding not to pursue ACOs. Are many delivery systems rejecting ACOs in favor of developing their own limited network insurance product, sometimes in partnership with an insurer, for the Medicare Advantage markets and the ACA marketplaces or private exchanges?

So this is somewhat of a return to what we were talking before but in a sense, do you see evidence of providers making the calculation, look, I'm already efficient. If I get an ACA contract, I'm going to have to become more efficient to do well. Why don't I capture that efficiency by, you know, having a contract that's pegged to community experience like Medicare advantage or like a plan in exchange?

**Matthew Borsch:** Well, if I could just take a crack at this one. Of course, when we use the term ACO it can be used in different context with the pioneer ACO program, which has not had the momentum that proponents had hoped it would as compared to all the various private ACOs that get announced in various forms and press releases by health systems, by payers that are helping put those together. How many of those are real versus arrangements on paper that may or may not eventually become meaningful remains to be seen.

There are new ACO arrangements in that sense are continuing to emerge every day. So I'm not sure we can say rejecting ACOs except if we mean the Medicare ACOs in favor of developing their own limited network insurance product -- you're seeing both and you're seeing ACOs that are, in effect, limited network insurance partnerships in partnership with the payer and then, less frequently you're seeing health systems offer their own products, Medicare advantage and on the exchanges.

**Ana Gupte:** One thought I think that we didn't cover, you know, which I think is maybe obvious and maybe underappreciated is that when a health system comes in to do a limited network insurance product and underwrites risk, that they put a certain amount of capital. And it's typically rule of thumb about 10 percent of the health insurance premiums that are underwritten, is ring-fenced as risk-based capital.

And let's even leave a part of the capabilities and the skillsets and, you know, hospitals and do they have any business underwriting because they're not capable of doing it, the end of the day it's capital. And I've heard sort of one of the theses that I get asked about is in the long run will we just have a proliferation of health systems that each underwrite in their own limited network insurance product and eventually disintermediate health plans? And I think the truth of it is that we do spend almost $3 trillion in this country and when you think about how much of that is underwritten premiums at 10 percent, that's a massive amount of capital that I don't think even exists in these systems.

**Paul Ginsburg:** That's a good point. We've been focusing on providers' perspectives on these payment arrangements. I'd like to turn to plans since we've heard some comments that plans are
doing a lot of this, private plans. But is this -- how would you characterize their interest in payment reform and also, a few years ago we used to hear about, well, when there are dominant plans in local markets they don't feel much motivation to go into the space. So what does it look like now?

Ana Gupte: I think plans have always been interested in payment reform. Maybe there are two stools to the whole equation of cost trend moderation and with all of this broader healthcare overhaul, not just Obamacare, the pressure on plans to "approve" their value proposition and moderate cost trend is just critical to them. There's an existential risk if they don't and you have consumerism and they are stretching the envelope on high deductible plans, penetration, the level of the deductible but the if they don't get payment reform and to some degree start eating away at the physician first and over time into health systems and then, finally, I think even the for-profit hospitals come their way. It's very challenging for them to achieve the next level of cost trend moderation that we've been talking about going forward.

That being said, of course, if they work with self-insured employees like Boeing who may even consider disintermediating them and contracting directly with some of the local health systems, that's not the type of payment reform I think that they're seeking. It's looking for a win-win solution where there is shared risk. They're willing to bring their capital and their balance sheet to bear and they're willing to bring their underwriting capabilities and increasingly companies like United with Optum, and increasingly, I would expect Aetna and Humana and the others as well, will bring more coordinated care management processes and tools and technology in enabling these health systems to underwrite this risk in a calculated and intelligent manner.

Matthew Borsch: Yes. And if I could just add to that. So you again make a contrast with the late-90s when I think what we saw from health plans at that time was many of them were just flat out reluctant to get into fair and supportive risk arrangements with provider systems that were interested in doing that. And where they did, they were often lopsided deals that weren't adequately supported by the plans. It seems like we're in a different era now 20 years later where the plans are really pushing for this to happen successfully that there's an awareness that they can't push too much risk too quickly. That they have to provide a lot in terms of support and so I think it is real and there's to some degree a race among the plans to see who can make this happen the most quickly.

Paul Ginsburg: Good. And have plans worked out an efficient way of doing this and involving their customers from self-insured employers?

Matthew Borsch: Not really. Not yet.

Paul Ginsburg: Yes. So this is an obstacle of that because that's about half of their business?

Matthew Borsch: Right. More than half.

Paul Ginsburg: More than half, yes. So maybe that's more -- what about finding providing partners that they think are capable of being on the --
Matthew Borsch: Paul, if I could just go back to the --

Paul Ginsburg: Sure.

Matthew Borsch: -- self-insured employers for a second. This is going to be an evolving area to watch. I think if you went back just a couple of years ago there was a great deal of enthusiasm that sort of burst suddenly on the scene over private exchanges. And in particular, the hope perhaps that you would see a shift start by self-insured employers back into fully-insured arrangements as the best way of being in private exchanges and that this would bring the whole purchasing, start to bring it into a structure that would really support population-based reimbursement for provider systems.

And to some degree it's been a disappointment and a fizzle in the last two years, at least relative to how great the hype was. That said, as with many things in healthcare, change takes a long time. If you think about where we are with adoption of private exchanges, not that they provide all the answers, they don't but we are somewhere around the adoption rate that we were with consumer-directed health plan products back in 2004, 2005. And now as we saw from the most recent Kaiser survey those products are adopted by about a quarter of all commercially covered lives in the US.

And we, you know, but that's a -- that would suggest somewhere along the lines of mid-decade getting to something similar if that is going to, in fact, be the structural change that we see for self-insured employers. It may be something else.

Paul Ginsburg: I see. So you're thinking perhaps through private exchanges and that I take it, it doesn't work now to get the permission of each self-insured employer. You know, we have this ACO contract with hospital A, system A. It is okay with you that we pay these rates and these bonuses?

Matthew Borsch: I mean, that may work. That may ultimately, you know, it'll be worked out in that direction. We don't know yet.

Paul Ginsburg: Okay.

Sheryl Skolnick: But to answer the question that you asked. So I think there are generally speaking a large number of provider systems who are willing to be partners with managed care either on their terms which are not the managed care plans' terms or who aren't really ready to take the risk. And sometimes, as was mentioned, I think by Ana that the plans have to back away because if they're going to bring this to the market, if they're going to commit capital and sign up members, they're going to be on the hook for this and you can't have your partner fail.

So since managing populations is a different strategy for hospitals, it's just taking a very long time to build that level of expertise where you can have a dependable well-functioning market with appropriate protocols for treating these patients that will generate predictable enough results to minimize the risk of entering the relationship for the plan.
Paul Ginsburg: Yes.

James LeBuhn: I think that's interesting you brought up in Seattle with Boeing. Again, on the not-for-profit side, I think as you -- as I think about value-based reimbursement, population health management and particularly the large employers who generally they have an ASO, they're taking the risk. They're asking the providers and the physicians to take the risk. And the providers and physicians, I think, are sort of looking at that. And if you've got the scale in a marketplace it's like well, why do I need to, I mean, what's the benefit that the insurance company brings? I can just do that direct and then, not have to share the benefits with that organization.

And so I think you're going to see again, consolidation, as you said. What I expect is that those organizations that have the size and scale are dipping their toe in a lot of different areas to see where things are going but they are transitioning to becoming healthcare -- a healthcare company not a hospital provider.

Paul Ginsburg: Yes. You know when plans look at bundled payment or ACOs, do they have a preference or do they think both are worth pursuing? Or do you see that one is getting the priority because of seeing that as having more opportunities?

Sheryl Skolnick: I think Matt would give you the really professional answer of it's really hard to say and I'll give you -- this is the difference between Goldman Sachs and Misuzio. And I'll give you, in a lot of cases you throw it up against the wall and you see if it sticks because it's really uncharted territory. You don't know what's going to work. And even if you think you know what's going to work, the marketplace is -- it's complex, it's fungible and the incentives are at cross purposes oftentimes that the hospitals aren't where the plans are. The doctors aren't where either the hospitals or the plans are and if you don't have all three in alignment, understanding and capable of achieving the same goal, not going to work.

Paul Ginsburg: Yes.

Matthew Borsch: One other comment just on these arrangements I'll offer is that the place where we've seen the outcomes demonstrated most strongly has been in the West Coast market, in California in particular.

Sheryl Skolnick: Yes, which makes a lot of sense.

Matthew Borsch: And not all of the success but the predominant chunk of it has been with physician-driven models. And so what's interesting about the development is ACOs is in so many markets outside of California, as they've recently evolved, they've been hospital-centered rather than physician-driven and one can make an argument that's got to change in order for them to be successful. They really should be much more physician-directed.

I'm not necessarily endorsing that view as right although a lot of certainly those California physicians would probably back that. The reason that hospitals have emerged at the center of
these new ACOs is because they're the only large organized party with at least some access to capital and systems and economies of scale in these markets that can step forward to do that.

Paul Ginsburg: Yes. And I'm glad you pointed out California being different in so many ways. And one other difference is that say for these physician organizations, they have long standing experience with much greater degrees of risk than an ACO. And they see the ACO as just, oh, we already have the infrastructure. Maybe we can do something in the Medicare fee-for-service population or the commercial PPO population because -- but we would much rather do this for a higher degree of risk as we have in other populations.

Topic on narrow network plans and we've seen particularly in the marketplaces and it's probably the case in private exchanges, too, narrow network plans taking a very large share. And to the degree that you've followed it, to what extent are the networks in these plans being built on low unit prices versus broader measures of spending like per episode or per year?

Matthew Borsch: I think to the extent we have some visibility on that, it's that they're being built more frequently around per bundled or population-based reimbursement mechanisms, although certainly there are some elements of lower unit-based reimbursement as well. The success and traction for narrow network plans I, my opinion, going to depend a lot on how much of the plan's selection is at the retail level versus continuing to be at the group level.

Having said that, it's interesting, just recently there's been a bit of an emerging trend around employers moving back to slice contracting, large contracts. I'm sorry large employers moving back to having more contracts rather than for the last 15 years it seemed every year it was contract consolidation. Fewer and fewer carriers and now, all of a sudden, there's a little bit, I don't want to overplay it, but some movement in the direction of more slice contracting. So that's going to be something to watch.

Sheryl Skolnick: So what we saw originally from what, if you listen to what the for-profit hospitals will tell you is for exchange contracts and the like it was a small discount between 5 and 10 percent at most off of traditional managed care rates with the hope that you could get a fair amount of the volume from that plan although I don't think there was any real guarantee of volume because the plans couldn't guarantee volume and they didn't know at the time how many members that they would ultimately have which was, again, if you can't guarantee volume, then it's really hard to negotiate a more creative and potentially innovative contract structure.

So from what I see I think if you were to poll the publicly traded hospital companies, they would tell you that they are seeing an increasing number of their managed care contracts being tied to quality or value-based payments in some way, shape or form, but I have seen no data to suggest that that quality arrangement is a bundled arrangement. But rather it's a benchmark achievement arrangement.

You know you've reduced your readmissions. You've reduced your hospital-acquired infections type of, you know, you've maybe improved some outcome measure rather and you
get a bonus for that rather than some of the newer innovative arrangements. But not really tied to a narrow network. It seems to be network-construct indifferent.

**James LeBuhn:** And right now, the value-based payments are, I mean, they're teeny.

**Sheryl Skolnick:** They're teeny. Yes. They've very small still.

**James LeBuhn:** Yes, it's funny. I mean, we talked with organizations. They say, well, 15 percent of our contracts are value-based or 15 percent of our reimbursement and then, when you ask what the delta is, it's -- I actually scratch my head and go why even invest in it?

**Sheryl Skolnick:** That's right, yes. And oftentimes what you're doing is giving up on the base rate in order to get it as a bonus later and you don't even realize it.

Jaes LeBuhn: Exactly. Yes, there's no downside. Yes.

**Sheryl Skolnick:** Yes.

**Paul Ginsburg:** Let's move on to large employer health benefit strategies. Of course, that's a really big part of the insurance market and first question is to what extent are large employers taking steps now to prepare for the Cadillac tax?

Ana Gupte: I can take that. Well, I think right now they're just utilizing all the levers at their disposal to manage cost trends down without doing anything drastic like moving out of group insurance into private or public exchanges in any meaningful degree. And so the types of things are, you know, the obvious ones.

I think high-deductible health plans are clearly seeing a pretty dramatic acceleration in the penetration, the size of the deductible. They're employing as much as they can, more population health management techniques. It works much better in a large employer organization where your insurance company together with you. There is so much data that's available on your employee population to be able to stratify risk and target interventions where they have the highest return on investment and you can reduce your hospital admissions and readmissions and so on.

As we start moving probably into, you know, 2017 you might begin to see a little bit more adoption I think of the private exchange paradigm. Though here, too, our forecasts say that you won't really -- this is more evolutionary than revolutionary. You won't really see much major change happen until maybe even the early to the middle part of the next decade, if you will.

**Matthew Borsch:** And just to add to that, I think 2017 is going to be the interesting year to watch of course because most employers, while they're engaging in planning, they may have made some changes, they're really waiting to see what happens. What happens in the November election outcome next year and then, following that, what happens with policy, what happens with regulation writing, what does Congress do?
But we're going to get into a very short timeframe for stuff to happen versus, at least for some employers, many of them will not be immediately to the Cadillac tax threshold but for those that are, they're going to have put -- they're going to have to have a plan and be ready to implement that plan very quickly. And it may be drastic in some cases because they won't necessarily have gotten on a gradual approach to get down to where they need to get to be under the Cadillac tax threshold because they're waiting to see what will happen.

And I think the expectation from many people, if not most, is that the Cadillac tax will be either pushed out or watered down through regulation, maybe even eliminated.

Paul Ginsburg: Yes. You know, Matt, I was surprised about two years ago, I think, started seeing surveys coming from the benefits, the consulting firms that survey. And we're talking about steps being taken now. And I know back then it was probably less uncertainty about whether the tax is going to go into effect but it was really many years out which would imply the importance of avoiding a sharp change just before it went in.

Ana Gupte: Well, I mean, I think just to, you know, maybe that's where you were going or not but these benefit consulting firms have their own incentives around fostering the adoption of private exchanges, right? Because they're always concerned about disintermediation with the public exchange as a channel that might take hold to a greater degree.

And in some ways, maybe, as we're discussing the sustainability of the marketplace and its health and on the public exchange arena that might help some of the private exchange penetration. But the distribution side of employer health insurance is so often been the driver of adoption patterns by employers that need not necessarily make fiscal sense. And the whole notion of best of breed where you still have standalone PBMs and they're trying to segregate each component of benefits rather than have kind of integrated value propositions take hold are all things that the Towers and the AONs and Mercers of the world are fostering.

Paul Ginsburg: Good. Before I get into my question, if anyone has additional questions on blue cards this would be a good time to write them down. Hospital employment of physicians, how much further will the trend go? Say 5, 10 years from now, what are we going to see?

Sheryl Skolnick: Well, I think we are a long way from being done on that score yet. The losses associated with owning the practices or employing the physicians aren't great enough to cause enough pain for the hospitals to stop. And forgive my cynicism but I don't think anything changes over time and I don't think hospitals have become better managers or better aligned with their physician partners and employees than they have been in the past.

But it is crucial for them to make sure that they have that, we'll call it alignment, whether it's employment or control over the practice in some way, shape or form, to be able to manage under -- if any or all of these payment, alternative payment changes come, owning or being aligned with the physician is ultimately crucial for the hospital. And primary care in particular because as your reimbursement gets compressed, you need to shift the patient into outpatient.
You need to be part of that process. You need to have visibility into that process. And you also need to get paid for those services as a separate source of revenue while you're controlling it. So I think that as the power base within healthcare shifts to, because doctors aren't going to organize among themselves and they have to be organized. And so as the power base shifts to large more well organized, maybe not at national scale, but certainly at local scale organizations, they'll -- and as dealing with managed care companies is difficult and as reimbursement is limited, there's going to be this push up from the physicians and down from the hospitals.

And we'll see this continued consolidation until the point of pain comes and I'm not sure when that is. When we realize that either the payment models that necessitated that consolidation didn't evolve or they evolved but still don't compensate the combined entity for their combined value, in which case, they'll split apart again.

**James LeBuhn:** Yes, well, and I agree with you. I think the -- what we're seeing, there's a lot of competition, at least on the not-for-profit side, for primary care is kind of where it's at. I think for a while there were, you know, kind of well, we want to get the specialists. Now that has worked against some organizations.

And to the extent that the hospital can absorb some of those costs to help align incentives, I think that is right now, that's still sort of the name of the game. And again, it depends on what your market is. Why you're acquiring some of those physicians? I mean, we've got some hospitals and they're kind of the only game in town. They're like, why am I going to acquire my physicians? Why am I going to absorb that cost? I'm not picking up any market share there.

I think when we talk with organizations, the younger physicians coming out, we hear pretty loudly they want to move into the employed model. And so we're sort of in I think this transitory phase where you've got older physicians that are independent practice physicians that want to remain that way and it depends on the marketplace. As we were saying, in California, it's much more -- it's much further ahead than large parts of the country, particularly the East Coast tends to be community-based independent physician model.

**Sheryl Skolnick:** But it's even changing in the East Coast. Some medical group has bought up virtually every practice in affluent Essex County, New Jersey they can find and avoided every practice in the less affluent parts of, and not surprisingly, because they can. And that tells you something. They're preparing to do something with that.

The other issue here is that it's not just hospitals acquiring physician practices or large group practices. It's also some of the health plans like Optum. And with mixed success but I can tell you was a real learning experience for United Healthcare, Optum, the Optum part of United Health Group actually. I should be careful here, sitting opposite Anthem in California with their physician groups that they owned negotiating rates as a provider.
This was a truly humbling and learning experience for them that was probably necessary. But that was part of the reason why they bought those practices was to learn precisely that. To figure out what was broken.

**James LeBuhn:** One of the things that's interesting as well is physician leadership on the hospital side. You really see that in some of the larger organizations if you look at Providence, if you look at Banner, if you look at Aurora up in Wisconsin. Generally, you're seeing physician leadership. Those are being run by physicians and I think it brings that perspective to the organization and it probably brings some credibility when they're going out and negotiating with different hospital or physician groups whether it's a full employment or some sort of alignment model.

**Sheryl Skolnick:** Yes, I mean, one of the things I was really worried about as we were on the cusp of reform was this whole question of leadership and who would be the leaders who would take the hospitals, in particular, but also to some extent the health plans, into this new uncharted territory of how to behave under increasing regulation. Not so much the expansion of coverage part that was the easy part. It was all of the increasing regulation and all of the shift to value-based payments and the world changing around them.

Because you saw this wave of retirement of the old and in the for-profit space, actually, in the publicly traded companies, we've seen some retirement but not a whole lot. We're kind of in anticipation of some retirements, some more eagerly than others shall remain nameless. And that's also in part because the success or failure in managing through this whole process, physicians are part of that but it's just the overall, overarching thesis for the hospitals is right now physicians fill beds, that's why I want them.

As opposed to physicians heal patients that's why I want them. The most forward-thinking hospitals are buying them because they heal patients. The majority are buying them because they fill beds.

**Paul Ginsburg:** Yes, so if you can envision, go out five or more years where population health has become more substantial, where the trend of younger physicians wanting to be employed has progressed further and perhaps there'll even be a time there will be, hospitals will decide, I'm really pretty bad at this. I can be better spinning off this group and aligning with it. And maybe some of them will be picked up.

Maybe plans will be better at it than hospitals. But could you see a world where the managers of the hospital -- of the physicians, it's a competitive process; who's best at it?

**James LeBuhn:** I mean, I still think that the trend is towards hospital-based employment of physicians. I mean, if you look at bundled payments, you've got to have the hospitals and the doctors together. Who's going to split up those dollars? And so I think as Sheryl was saying, the alignments, I mean, one of the big problems in healthcare is that all the incentives are misaligned.
And I think over the longer term, obviously, there's going to be some bumps in the road because there isn't -- there's still an unalignment of incentives. But you're going to bring that more into focus, I think, going forward.

Matthew Borsch: Yes, I just would caution that may be the outcome but we'll see because the most successful models have been physician driven and frankly, most of the hospitals don't like that model because at the end of the day, they're one of the downstream vendors in that model as are other providers of services. But that's the one that's shown -- has yield -- heretofore shown the strongest cost-effective and cost and quality outcome evidence.

James LeBuhn: I think one of the interesting things, too, that the recent announcement that CMS is going to pay for when you acquire a physician, one of the incentives has been or one of the subsidies as I acquire that physician group and then, all of a sudden I can bill for certain services under my hospital code and get a much higher reimbursement. And they've said, okay, well, we'll grandfather that in but going forward, no more. So that may be something that would sort of --

Paul Ginsburg: No more. Yes, in fact, I've even seen in California where in one area there were hospital systems doing joint ventures with radiologists on imaging and other -- and surgeons on surgery centers and deliberately keeping them outside of the hospital despite the bump up in hospital rates because they were concerned they wouldn't be competitive as a system. Contracting with health plans, getting into narrow networks, so in a sense, a lot of this is how evolved things become and how competitive the market is as to, yes, there's a short-term incentive and we get paid a lot more if we hire the physicians. But that could be a liability down the road.

James LeBuhn: Right. But I think going back to Sheryl's point that there were maybe some, you know, that was a way to subsidize maybe a strategy there that maybe didn't make great strategic sense over the long term.

Paul Ginsburg: Yes. Good point.

Ana Gupte: I guess in the end state though coming back to a point I think Sheryl made around capacity shake-out and this whole notion of filling beds is because there's the overcapacity in this whole system. And will we ever get to that, five, seven years from now will we get to that end state where the hospital is no longer so over-capacitized that all they're thinking about is filling the beds. And, at that point, it's more about the physicians being the ones that are actually treating and healing the patients as opposed to this whole notion of referrals driving every piece of their behavior.

Sheryl Skolnick: Well, one can always hope and it's the direction that they have to go in. But I am, I mean, I'm -- look, I'm a fan of the hospital system generally speaking in terms of all the progress that they've made on a lot of fronts. They've really tried very hard not just the for-profits and the not, but taken all together, they've tried very hard to embrace value-based payments and moving their businesses forward to achieve a different kind of outcome and be participants in the reform process that the law only hinted at.
And so I'm a fan of that and I would encourage that but I'm highly skeptical of us getting to that almost idealistic state where they finally let go of the paradigm, the business paradigm, that they were created for that they've succeeded with for years and years and years through thick and thin. You know the mid-nineties was a horrible time for them but somehow they succeeded to the early 2000s when all their beds were full and they were getting paid out the wazoo and some store volumes were growing at five or six percent a year.

So that cyclicality of it makes it that the good times will come back makes it really hard to give up the potential that the good times come back. So I am very cynical. It shouldn't be a surprise to anybody now.

**Paul Ginsburg:** I've got a bunch of questions here. I guess I can't get to them all. Can you talk about hospitals in underserved communities? How are mergers, payment changes affecting them and is there any hopeful strategy for them?

**Sheryl Skolnick:** It's probably more in your space but I'm happy to take it.

**James LeBuhn:** Yes, I'll go after the -- we don't rate a lot of the inner --

**Sheryl Skolnick:** Yes, because they don't really -- yes. So there are a lot of hospitals in a lot of locations that are going to either close or become freestanding emergency rooms or something akin to that simply because you -- there's just not going to be enough money in the system to sustain a full blown hospital.

They will -- I think there used to be 58 rural hospitals, one for each county in the State of Iowa, without trying to offend anyone from Iowa, believe me. And part of the reason for that was Senator Grassley's generosity that he made sure they all stayed open. And there was big defense of rural hospitals when he was in Senate Finance.

And it was a great time for the for-profits. It was a great time for the rural communities. But unfortunately, a lot of hospitals were built because there was excess margin in that business and they were monopolists and now there's not.

So I think what you're going to see is the definition of an underserved community is unfortunately they're going to be underserved for some time to come. One of the programs that HCA has actually been using quite effectively has been a transfer program where the local primary care physician retains control over the patient, is connected via telemedicine and systems, technology, to maintain a hand in treating and control over that patient and being part of the decision-making process when that patient it transferred to a more urban center of excellence for more complex care. And then, the patient is returned back to the community.

And they have found that to be very successful. It builds a good relationship with the local community. The patient outcomes are good and the costs are controlled. So they are using this wherever they can to address the issue of underserved communities.
James LeBuhn: Yes. I was thinking more safety, inner city safety net hospitals but --

Sheryl Skolnick: Well, they're not so dissimilar.

James LeBuhn: Yes. But I agree with you. I think the -- when you look at the rural hospitals, I think the other thing there is just the demographics are working against them as well.

Sheryl Skolnick: Population's dropping like a stone.

James LeBuhn: The population's moving into urban centers and generally speaking, I think when you see a lot of the, you know, for (inaudible) Beckers and you see some of the critical access hospitals that are filing for bankruptcy, what do they? Inpatient ad -- or I mean, inpatients they have four patients? I mean, you can't support it.

Sheryl Skolnick: Four patients. Even at 25 beds you can't sustain it.

James LeBuhn: Yes, exactly. And so I think that, like you said, the ability with telehealth, with improved IT you can do those consults and really I think what you're going to see over time is some of those critical access hospitals, depending on their demographics, are going to turn into essentially emergency rooms where they can transport patients. I agree with you.

Paul Ginsburg: Yes. And, Sheryl, this question here what do you see in the coming out of the Duke LifePoint joint venture?

Sheryl Skolnick: It's been a very opaque --

Paul Ginsburg: You should probably tell people a little bit about that.

Sheryl Skolnick: Yes. So a number of years ago, LifePoint was having a lot of trouble maintaining decent quality of care out of a particularly large hospital acquisition they made in Danville, Virginia. And made a commitment to dramatically improve the quality of care that they delivered and stability of their hospital system and their acquisitions going forward and was looking for a partner to help them to move it forward on, to their credit, move forward on that agenda.

And so they contracted through a joint venture with Duke which in that Danville, Virginia on the North Carolina border was a perfect partner for them since they owned five hospitals right along the highway route. And they did, in fact, dramatically turn around the Danville hospital and improve the quality of care.

And since then, they've expanded that joint venture to -- and they used the Duke LifePoint which carries a great brand of quality of care to start an outpost in a new market. So for example, in Marquette, the first acquisition that they made was via Duke LifePoint and then, they ring it around with other facilities with either a LifePoint branded hospital or a Duke LifePoint branded hospital or physician practice or ancillary service.
And so what I think will come out of this is, and the problem that I have with it is, we have no idea how much money Duke is making off of this. We have no idea whether it's actually accretive to LifePoint's profits in a meaningful way except to the extent that they consolidate results which must mean that they have a 51 percent claim on profits but maybe not.

So -- because there are some accounting rules that would allow them to consolidate without that. So I don't like things that I can't see. So I'm a little cynical about that but having said it, it's been tremendously successful because they're bringing to smaller cities and other smaller marketplaces an approach to quality of care coming from Duke that seems to be working. It seems to be generating better outcomes. Their readmission performance actually is better than Tenet or HCA's according to the most recent data which was kind of surprising.

They'll have a much smaller effect, they'll actually get a slight increase overall on average for all of their facilities except at the Duke LifePoint ones. There the readmissions are still high because they're relatively new acquisitions. So and they're working on those. So they're making some progress with that and I think what ultimately comes out of that is that you see more hospitals being branded as Duke LifePoint through this acquisition strategy. Still a limited number and then, the rest of them will be LifePoint hospitals.

Paul Ginsburg: Thanks. And do you see interest in other companies of doing similar things or is it too early?

Sheryl Skolnick: I think it's probably too late actually. No, I mean, in terms of the notion of having to partner with someone to improve your quality without being able to do it internally is something that Tenet nor HCA needs because they started their quality improvement programs a long time ago.

The one who could probably use a little bit of help with some of it is Community. And they've got other issues right now that they're dealing with. So they're not in a position to do that.

Paul Ginsburg: Okay, thanks. Well, regretfully, we've run out of time. And time went quickly. And I want to thank the panelists who did a really terrific job. I want to thank the JKTG Foundation for funding the event and also thank the USC Schaeffer Center and its staff and consultants for putting this on. Thank you very much.